THE PHENOMENOLOGICAL EXPERIENCE OF CROSS-CULTURAL DIFFERENCES IN THE THERAPEUTIC RELATIONSHIP

by

James Patrick Asbrand

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STATEMENT OF DISSERTATION APPROVAL

The dissertation of **James Patrick Asbrand**

has been approved by the following supervisory committee members:

Susan L. Morrow	, Chair	**12/5/11** Date Approved
Lois Huebner	, Member	**12/5/11** Date Approved
A.J. Metz	, Member	**12/5/11** Date Approved
William A. Smith	, Member	**12/5/11** Date Approved
Lauren M. Weitzman	, Member	**12/5/11** Date Approved

and by **Elaine Clark** , Chair of the Department of **Educational Psychology**

and by Charles A. Wight, Dean of The Graduate School.

ABSTRACT

The therapeutic relationship has been a cornerstone of the theory and practice psychotherapy since it first emerged as a healing modality. Evidence of the power of the therapeutic relationship between client and therapist has been extensively reported. Despite the recent emphasis on multicultural awareness and competency in psychotherapy, an important question remains regarding the impact of cross-cultural differences on the therapeutic relationship. Using a phenomenological qualitative methodology, his study examined the lived experience of both clients and therapists in a cross-cultural therapeutic relationship.

The results of the 26 participant interviews representing 13 distinct client/therapist pairs with one or more cross-cultural difference yielded two areas of phenomenological description with several themes and subthemes. In Part I, *Experience of Relationship*, participants described the lived experience of the therapeutic relationship from the initial referral process and development of the trust to the various factors that contributed to developing and strengthening their relationships, including past experiences, initial expectations, behaviors and attitudes that facilitated trust, a sense of mutual commitment, and sincere emotional connection. Four major subthemes were identified in Part I: *Referral and Initial Impressions, Development of Therapeutic Relationship*, *Shared Investment*, and *Emotional Connection*. In Part II, *Experience of Differences*, participants described the phenomenological experience of meaningful differences between clients

and therapists in the same therapy pair, including their awareness of differences, how differences impacted personal identity and the therapy relationship, similarities in their relationships, and the intersection of power and identities in the relationship. In this part, four main themes also emerged: *Dimensions of Identity*, *Differences as Enhancing the Relationship*, *Building on Common Ground*, and *Power and Responsibility*. Conclusions of the study are considered in terms of limitations and implications for future research, practice, training and social justice.

I would like to dedicate this manuscript to the countless therapists and clients who engage one another in the important, difficult, and transformative work of psychotherapy every day. You make a difference.

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CHAPTER 1

INTRODUCTION AND REVIEW OF THE LITERATURE

The irreducible elements of psychotherapy are a therapist, a patient, and a regular time and place. But given these, it is not so easy for two people to meet. We all live on the hope that authentic meeting between human beings can still occur (Laing, 1967, p. 26).

There are many definitions of psychotherapy throughout the research literature as well as in popular culture. The American Psychological Association (2004) describes it as a partnership in which a professionally trained therapist helps another person to understand feelings and change behavior. Jerome Frank (1991) stated that psychotherapy is a ". . . planned, emotionally charged, confiding interaction between a trained, socially sanctioned healer and a sufferer" (p. 24). Wampold (2001) identified four key components of psychotherapy that seem to be present across all definitions. These defining characteristics of psychotherapy are: 1) it is primarily an interpersonal treatment modality; 2) it involves a therapist and client; 3) it is remedial; and 4) it may be individualized to the needs of the client. One of the most important aspects of psychotherapy, its interpersonal and dynamic nature, is represented in the therapeutic relationship.

Since then, the efficacy of talk therapy as a healing practice has been demonstrated by empirical research (Lambert & Archer, 2006; Wampold, 2001), and there has been an emergence of over 250 different schools of psychotherapy from various

theoretical traditions (Henrik, 1980). Empirical research has found that, regardless of theoretical orientation or therapy school, the therapeutic relationship stands out as one of the most powerful predictors of psychotherapy outcome (Horvath & Symonds, 1991; Norcross, 2002; Orlinsky, Grawe, & Parks, 1994). Although there has been an extraordinary amount of research on the practice and technical aspects of psychotherapy, far fewer studies have examined the therapeutic relationship and the impact of cultural differences on this core element of the therapy process.

The purpose of this study was to explore the experience of cross-cultural differences in the therapeutic relationship for both clients and therapists. The lived experience of the cross-cultural therapy relationship was examined in addition to the impact of identified differences between client and therapist on the relationship and process of psychotherapy. The efficacy research on psychotherapy is discussed in the next section, followed by a review of the research on the effectiveness of psychotherapy interventions highlighting the emergence of the empirically supported treatment and evidence-based practice movements in addition to the research on common factors in psychotherapy. Finally the existing literature on the therapeutic relationship is reviewed, highlighting findings on cross-cultural differences in psychotherapy.

Psychotherapy Efficacy

Research examining the overall efficacy of psychotherapy began primarily as a response to Eysenck's bold assertion in 1952 that the rate of success in psychotherapy was no greater than the rate of spontaneous remission of mental health problems. Throughout the 1960s and 1970s, research in psychotherapy gained ground but struggled

with criticisms regarding poor methodology and inadequate research design, and there remained a tremendous disconnect between laboratory research in psychotherapy and clinical practice (Nathan, Stuart, & Dolan, 2000).

In recent decades, as quantitative research methodologies have improved and the clinical utility of research has been emphasized, there has been an overwhelming amount of empirical evidence confirming the efficacy of psychotherapy as a treatment modality (Joyce, Wolfaardt, Sribney, & Aylwin, 2006; Lambert, & Bergin, 1994). The introduction of meta-analysis and effect size has unquestionably established that the rate of success in psychotherapy is greater than the rate of spontaneous remission (Joyce, et al., 2006; Wampold, 2000). In fact, research suggests the average psychotherapy client is better off than roughly 80% of people who do not engage in treatment (Lambert & Ogles, 2004; Wampold, 2007). As psychotherapy has accumulated evidence of its overall efficacy, societal attitudes toward mental health treatment have also shifted considerably from stigmatizing to acceptance (Harris Poll, 2004; Penn, Schoen, & Berland Associates, 2004). The accumulation of efficacy research, however, has often failed to uncover the true nature of the curative elements of psychotherapy as well as how these elements are experienced by those who engage in the process, namely the therapist and client. The following section will discuss the attempt to identify the essential elements of psychotherapy, the rise of empirically supported treatments (ESTs), and eventual emergence of evidence-based practice (EBP).

Empirically Supported Treatments

Once the question of psychotherapy efficacy was settled, the research focus in clinical and counseling psychology turned to prescriptive treatments and specific ingredients involved in therapy (Sperry, Brill, Howard, & Grissom, 1996; Wampold, Lichtenberg, & Waehler, 2002). As different schools of therapy emerged and new therapeutic techniques were developed to accompany them, there were increased efforts to identify those key elements of psychotherapy that are the most effective in the remediation of specific psychological problems (Norcross, 2002; Wampold, 2001). This movement to distill psychotherapy down to its most basic components was fueled by different parties with varying, and often conflicting, interests.

One major force contributing to this quest to identify the core ingredients of psychotherapy was the managed care industry, represented by insurance companies who draft policies and procedures dictating which mental health treatment modalities are worthy of coverage and reimbursement (Hubble, Duncan, & Miller, 1999; Norcross, 2002). As profit-seeking businesses, managed care companies are driven by cost-effectiveness. They are naturally interested in finding and approving those treatments that have been scientifically proven to produce the best outcomes in the shortest amount of time, with the minimal cost.

The other force came from within the field of psychology. This was the result of the many competing schools or brands of psychotherapy representing various theoretical orientations (Norcross, 1999). In this shortsighted "battle of the brands" (Hubble, Duncan, & Miller, 1999, p.5) competition, each school sought to promote its own type of therapy as superior to others, highlighting those specific techniques that distinguish it

from the rest of the field. Although this competition has abated somewhat in the past few years as the field of psychotherapy has evolved (Orlinsky, 2006), much of the damage has already been done. The long struggle for superiority created a splintering effect within the psychotherapy community and took the primary focus from the shared therapeutic aspects of psychotherapy common to all schools. This infighting for supremacy also served as a distraction, which in turn provided an excellent opportunity for those from outside the field, including managed care companies and government bureaucrats, to step forward and define the nature of the debate.

The pressure exerted on the field of psychology by both of these forces from within and without must be considered in the context of a general sense of inferiority psychology as a science has had since it first emerged as a distinct field of study (Norcross, 2002). Psychology as a behavioral or social science has struggled to establish itself as a valid field of objective knowledge and inquiry in comparison to the physical sciences. Psychotherapy, as a clinical application of psychological theories and principles, has struggled to establish itself over the past 100 years as a valid mental health treatment in the larger field of health care, which has historically been the exclusive purview of medical science and the medical model of treatment in Western culture.

Within this overall setting, a substantial amount of psychotherapy research was focused on identifying empirically supported treatments (Wampold, 2001). ESTs are those treatments, and their accompanying techniques, that have been shown through empirical research to be effective in the remediation of certain psychological symptoms or disorders (Joyce, et al., 2006; Norcross, 2002). These treatments largely depended on highly controlled, randomized clinical trials using manualized treatment procedures to

demonstrate their effectiveness. The assumption was that clients would improve based on their compliance as well as the therapist's proper use of techniques as outlined by his/her theoretical orientation (Wampold, 2001). The interest in ESTs fueled a search for the most effective, economical, and efficient mental health treatments. This development also effectively favored those therapy schools whose underlying theoretical structures were more easily operationalized and better suited to evaluation using simple outcome measures.

In 1995, the American Psychological Association (APA) Task Force on Promotion and Dissemination of Psychological Procedures published a list of ESTs for practitioners and training programs. Since then, several other treatment guidelines have been published in an effort to establish best practices in psychotherapy for specific disorders (Gatz, et al., 1998; Lonigan, Elbert, & Johnson, 1998; Task Force for the Development of Guidelines for the Provision of Humanistic Psychological Services, 1997; Wampold, Lichtenberg, & Waehler, 2002). These important research developments and official recommendations have certainly provided evidence that psychotherapy can be considered an effective treatment modality, challenging the primacy of psychopharmacological treatments put forward by the medical community (Norcross, 2002). However, they continued to fan the flames of resentment among therapy schools competing for favored status and insurance reimbursement money.

Fonagy, Steele, Steele, Higgitt, and Target (1994) reported that the EST movement is basically an example of consequentialism or the assignment of value to particular treatment models based solely on the measurement of their consequences or outcomes. Though, intuitively, this seems to make sense, there are a number of problems

with the consequentialist model as applied to mental health outcomes. One problem with the research on ESTs is that, although causal effects can be identified, there is no indication of just how these effects actually occur (Joyce, et al., 2006). Another problem as described by Norcross (2002) is that ESTs and the majority of practice guidelines "depict disembodied therapists performing procedures on Axis I disorders. This stands in marked contrast to the clinician's experience of psychotherapy as an intensely interpersonal and deeply emotional experience" (p. 4). In the context of the medical model, the patient/client is simply the site of the disorder not unlike any other (Bohart & Tallman, 1999). This view of psychotherapy disregards individual client and therapist characteristics as well as the therapeutic relationship, and it focuses on the specific treatment techniques as the cure for mental illness (Wampold, 2001). Consequently, over the last two decades, a great amount of research has attempted to identify those empirically supported treatments that have been proven in clinical trials to be effective in treating particular disorders (Beutler, 1998).

Until recent years, there has been far less attention given to the other elements of psychotherapy. This has begun to change as the field has slowly turned the focus of psychotherapy research and practice from ESTs to a more global perspective (Orlinsky, 2006). Orlinsky (2006) noted that, over the past several years, psychotherapy has evolved from the early *pre-paradigmatic* stage of science to its current stage of *normal science*. This represents a shift from "schoolism" (Hubble, Duncan, Miller, and Wampold, 2010, p. 25), where different models compete for attention and funding, to a research agenda more focused on developing a general psychotherapy paradigm. The current standard research model involves the study of "(a) manualized therapeutic

procedures (b) for specific types of disorder (c) in particular treatment settings and conditions" (Orlinsky, 2006, p. 2). Although this is generally seen as a positive movement in psychotherapy research, there is still a danger of one particular model gaining privilege over others (Wampold & Bhati, 2004). This is despite overwhelming evidence supporting the *dodo effect*, wherein all schools of therapy are equally effective (Wampold, 2001).

This new development in psychotherapy research, though hopeful, remains focused on treatment procedures and disorders applied in particular settings. Noticeably absent from this paradigm are the people involved in the practice of psychotherapy. In failing to include how individual client and therapist characteristics as well as aspects of cultural diversity impact therapeutic process and outcome, any new research paradigm seems destined to fall short of its goal.

Evidence-Based Practice

As a response to these concerns and the growing research findings on the importance of common factors in psychotherapy, and with an eye on policy shifts in other health professions, the field of psychology began to look toward the evidence-based practice movement as a way of reconciling the specific versus common factors "culture wars" (Hubble, et al., 2010; Norcross & Lambert, 2011, p. 4). In 2005, the APA Presidential Task Force on Evidence-Based Practice (Task Force) was created to address this issue. This Task Force (2006) developed the following definition for evidence-based practice in psychology: "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). This

definition, as a guidepost for future psychology research and practice, establishes three important points. The first point is regarding the best available research (Hubble, et al., 2010). The Task Force (2005) further defined this to mean "scientific results related to intervention strategies, assessment, clinical problems, and patient populations in laboratory and field settings as well as to clinically relevant results of basic research in psychology and related fields" (p. 274). This definition addresses the previous bias toward randomized clinical trials as the only legitimate source of empirical evidence, favored by proponents of ESTs (Hubble, et al., 2010). It also recognizes the importance of other types of research methods, including qualitative research, in informing clinical practice.

The second point included in the Task Force definition has to do with acknowledging the person and clinical expertise of the therapist (Hubble, et al., 2010; Wampold, 2010). The education, training, and interpersonal skill of the therapist play a significant role in psychotherapy; and the emphasis on integration of clinical expertise and research is an important nod to practitioners and their clinical judgment. After all, a great portion of the variability in therapy outcome is due to the therapist (Kim, Wampold, & Bolt, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003). Psychotherapists not only deliver the therapy techniques, but also engage clients directly and work to form the therapy relationship: the context in which the service is delivered.

The third aspect of the Task Force definition that sets a new course for psychotherapy research is the inclusion of the client as a unique individual and an essential variable in the psychotherapy process (Hubble, Duncan, Miller, & Wampold, 2010; Wampold, 2010). Rather than focusing exclusively on the treatment part of the

therapy dynamic, the Task Force definition offers the client, the very reason psychotherapy exists, a seat at the table. The Task Force (2005) acknowledged that therapy is most effective "when responsive to the [client's] specific problems, strengths, personality, sociocultural context, and preferences" (p.278). It is the client as the service consumer who ultimately decides how successful therapy will be. Each client brings a different set of concerns, values, cultural issues, identities, and beliefs to the therapy relationship. The research in psychotherapy must take this into account. Critics of EBP, however, argue that despite the inclusive definition this movement, similar to the EST movement before it, has continued to ignore cultural differences and the needs of minority populations (Sue & Zane, 2006). Before examining the impact of individual differences and culture on psychotherapy, however, there are certain nonspecific or common factors that have been found to occur across all psychotherapy models. These common factors will be discussed in the following section.

Common Factors

Despite the ongoing quest for the holy grail of specific therapy techniques, the preponderance of research evidence points to one simple conclusion; psychotherapy itself is effective, regardless of theoretical orientation (Hubble, et al., 2010; Lambert & Bergin, 1994; Wampold, 2001). The relative efficacy of psychotherapy has held up across a variety of psychological disorders (Benish, Imel, & Wampold, 2008; Cuijpers, van Straten, Andersson, & van Oppen, 2008; Imel, Wampold, Miller, & Fleming, 2008; Miller, Wampold, & Varhely, 2008; Wampold, 2001; Wampold, Minami, Baskin, & Tierney, 2002). Despite the appeal of being able to administer a specific technique to

alleviate a particular psychological disorder, much like a pill administered by a physician, it appears there are no superior schools of therapy or magic psychotherapy techniques that prove to be more successful than the rest. Quite simply, as Miller, Duncan, and Hubble (2005) pointed out, "Psychotherapy does not work in the same way as medicine" (p. 22). A growing body of outcome research in psychotherapy suggests that the nonspecific or common factors, previously discounted by medical model advocates, account for much more of the variance in outcome than previously thought (Wampold, 2001). These common factors are present and active in all approaches to therapy (Grencavage & Norcross, 1990). One criticism leveled at common factors research, however, is that it is largely correlational in nature (Joyce, et al., 2006).

Qualitative research on the common factors contributing to psychotherapy outcome has been focused on gaining a greater depth of understanding of these phenomena rather than quantifying outcome variance. The qualitative literature has made significant contributions in the areas of client factors, therapeutic relationship, and specific therapy techniques (Maione & Chenail, 1999). The history of research in psychology has been dominated by traditional quantitative methods, in which experimental research designs drawn from the physical sciences such as chemistry and biology are rigidly controlled for threats to internal and external validity (Choudhuri, 2003). Until recently, even multicultural research in psychology, in its early struggle to be acknowledged, employed primarily quantitative methodology. In the past two decades, the importance of qualitative research and its focus on the contextual meaning of individuals' experience in the clinical encounter has been embraced by the field (Choudhuri, 2003; Maione & Chenail, 1999; Rennie, 2004). While the psychotherapy

outcome literature has been based primarily on quantitative studies examining specific variables and their relationships to therapy outcomes (Wampold, 2001), and the multicultural competency movement has focused on developing guidelines for therapists (Pope-Davis, Liu, Toporek, & Brittan-Powell, 2001; Sue, Arredondo, & McDavis, 1992), a powerful force in qualitative multicultural research has emerged that places primacy on the lived experience and expectations of clients in psychotherapy (Atkinson, 1994; Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu, et al., 2002). Choudhuri (2003) explained that clinicians themselves use qualitative methodology in their everyday practice of seeking to understand their client's worldview, and so "it makes an elegant equation to do in counseling research what is done in counseling practice" (p. 272).

Based on prior reviews of the psychotherapy outcome research literature and analyzing over 100 separate outcome studies, Lambert and Barley (2002) concluded that there are four main factors that contribute to psychotherapy outcome. These factors are: extratherapeutic change, or those variables in clients' lives outside of the therapy experience, including personal characteristics, which accounts for about 40% of improvement; client expectancy, which accounts for roughly 15% of improvement in psychotherapy clients; specific therapeutic techniques, which account for about 15% of improvement; and common factors, or those factors common to all psychotherapy treatments, which account for approximately 30% of client improvement.

Extratherapeutic Factors

Extratherapeutic change or nondiagnostic client factors, includes outside events and circumstances in clients' lives and personal characteristics such as insight, motivation, and investment in the process and accounts for 40% of outcome. Awareness of extratherapeutic factors and how they might influence therapy encourages therapists to view clients as people rather than disorders (Bohart & Tallman, 1999). Research has demonstrated the importance of clients' internal and external resources in regards to making changes (Hubble, Duncan, Miller, & Wampold, 2010). About 43% of people (range of 18%-67%) improve without any formal psychological treatment (Bergin & Lambert, 1978). Many of these people seek out others whom they see as essential to their improvement and well-being, including friends, family, clergy, self-help literature, and self-help groups (Lambert & Barley, 2002). Interestingly, most informal helping groups and programs rely on warm, supportive relationships in addition to many of the therapeutic factors found in most formal therapy schools (Norcross, 2002).

This research highlights the need for clients to be seen as they are, active participants who shape and assess the therapy process from start to finish. As Lambert, Garfield, and Bergen (2004) observed, "Clients are not inert objects or diagnostic categories on whom techniques are administered. They are not dependent variables on which independent variables operate . . . [clients] are agentive beings who are effective forces in the complex of causal events" (p.814). This is consistent with the notion to *meet the client where he/she is* found across all mental health professions. In practice, however, the emphasis often remains on technique or therapist assessments of clients' needs. Hubble, Duncan, Miller and Wampold (2010) point out that, at this point in time,

"The field can no longer assume that therapists know what is best independent of consumers" (p. 36). The Task Force (2006) charged with researching EBP found that, among numerous client characteristics studied, there was sufficient evidence to indicate that reactance/resistance, preferences, culture, and religion/spirituality were effective in adapting psychotherapy. They also found that clients' stages of change and coping style were probably effective in adapting psychotherapy (Task Force, 2006).

Qualitative studies focused on extratherapeutic client factors have increasingly demonstrated the active nature of the client role in the therapeutic process. Rennie (1992, 1994) conducted several studies exploring the impact of the client in the therapy encounter. He found that client reflexivity, or active self-awareness and self-control, is an important factor and exerts influence on the process of therapy (Rennie, 1992). Using interpersonal process recall (IPR; Elliott, 1986), in which the client is first played a segment from a previous therapy session and then interviewed about the segment, Rennie (1994) found that clients' styles of storytelling may lead to increased self-awareness and may also be used as a strategy to avoid uncomfortable material or disclosures. Winefield, Chandler, and Bassett (1989) also found that clients can influence therapist behavior by using certain conversation patterns. They also reported that clients' communication styles may be seen as a reflection of empowerment or dependence on the therapist. Buttny (1990) described the importance of attending to verbal clues regarding perspective on blame and assigning responsibility in client stories.

Specific Therapeutic Techniques

Specific therapeutic techniques, which account for about 15% of treatment outcome, are the foundation of ESTs. This is, however, virtually the same amount of outcome variance as explained by client expectancy, or the placebo effect of engaging in treatment. While many psychotherapy techniques have not been tested in any formal way, the major therapy schools such as psychodynamic, behavioral, cognitive, and humanistic, have been studied extensively. Clinical studies report that the average treated client is better off than 80% of untreated control subjects (Norcross, 2002); but, as yet, there is no demonstration that any one school of therapy is better than others in treating depression, anxiety, or interpersonal issues (Bergin & Lambert, 1978; Luborsky, Singer, & Luborsky, 1975; Meltzoff & Kornreich, 1970). Meta-analytic reviews also weakened the case for the superiority of specific techniques with specific disorders (Wampold, et al., 1997), and several studies have failed to produce any compelling evidence for the relative superiority of any particular school of therapy (Gloaguen, Cottraux, Cuchert, & Blackburn, 1998; Lipsey & Wilson, 1993; Shadish, Navarro, Matt, & Phillips, 2000). Additionally, most clinical trials used to derive empirical evidence of the effectiveness of specific techniques do not include the types of diversity in their sample groups as exist in the broader population (Nezu, 2010). This also weakens the utility of specific therapy techniques across settings and clients.

Additionally, more recent studies have also strengthened the case for factors such as therapists' beliefs and clients' expectancy and hope. When therapists' allegiance to a particular treatment approach is accounted for, any difference in specific types of therapy is negated (Miller, Wampold, & Varhely, 2008). Also, when a placebo condition is

presented in such a way as to encourage expectations for a positive outcome, the effect produced is almost equivalent to that of standard ESTs (Wampold, 2007). Two important aspects common to all established models of therapy that seem to tap into allegiance, expectancy and hope, provide a structured explanation for clients' distress and a plan to achieve positive change (Wampold, 2007). It would seem, then, that the specifics of what technique or model is employed in therapy is not as important as the therapists' beliefs and allegiance and the clients' hope and expectations for positive results (Hubble, et al., 2010).

Qualitative researchers have explored some techniques or models of psychotherapy (Maione & Chenail, 1999). Several qualitative studies have focused on family systems therapy, seeking to understand the communication dynamics and therapeutic process techniques employed by family therapists (Chenail, 1993; Miller, 1987; Miller & Silverman, 1995; Stancombe & White, 1997; Troemel-Ploetz, 1977). Gale (1991) and Gale and Newfield (1997) studied a prominent solution-focused therapist's use of model specific techniques and subsequently identified therapy behaviors that the therapist himself was previously unaware he was using. In a qualitative analysis of Gale's (1991) data, Metcalf, Thomas, Duncan, Miller, and Hubble (1996) identified a familiar theme in psychotherapy research. They found that, although the therapist typically credited positive outcomes to the specific techniques employed in therapy, the clients were more likely to credit the therapeutic relationship.

Common Factors

Aside from extratherapeutic factors, common factors account for the next largest portion of improvement in psychotherapy clients – 30% (Lambert & Barley, 2002). The common factors label represents all those variables occurring within the psychotherapy encounter excluding specific therapeutic techniques and extratherapeutic factors the client brings into the session (Wampold, 2001). This includes facilitative conditions, individual therapist variables such as interpersonal style and attributes, and the therapeutic relationship (Lambert & Barley, 2002). The facilitative conditions most often identified as contributing to the therapeutic process are the basic client-centered conditions of empathy, warmth, and congruence communicated by the therapist (Lambert & Barley, 2002).

Orlinsky, Grawe, and Parks (1994) and Ackerman and Hilsenroth (2001) found a number of therapist variables related to positive treatment outcome. These include credibility, skill, empathy, warmth, confidence, honesty, flexibility, ability to provide affirmation, and the ability to focus on the client. Baldwin, Wampold, and Imel (2007) reported that therapist variables play a more important role than client variables in contributing to the therapeutic alliance. Other research findings, however, indicated that the client's perception of the relationship and the factors that contribute to it is most important (Lambert & Barley, 2002). Nezu (2010) pointed out that the therapist her- or himself is a stimulus with many different characteristics and qualities, including gender, race, age, weight, height, dress, hairstyle, office décor, etc. Each of these aspects of the therapist may be seen as pieces of information that can be interpreted differently (correctly or incorrectly) by different clients (Nezu, 2010). We know that some

therapists are simply better or more skilled than others. More effective therapists have been shown to achieve a 50% lower client dropout rate as well as 50% greater improvement in their clients (Hubble, et al., 2010). It is still unclear what the more effective therapists are actually doing to achieve better results, but some evidence points to better therapists using common factors to achieve more positive outcomes.

It must be emphasized that common factors contributing to therapy outcomes are not discrete additive ingredients that simply build upon one another in a linear fashion to achieve the desired result. There is no set ideal proportion of facilitative conditions, therapist variables, and therapeutic relationship that will automatically create a positive therapy outcome. The common factors are more accurately described as dynamic and interdependent variables that change as they interact with one another and with both therapist and client (Hubble, et al., 2010). The participants in the therapy encounter influence these common factors as well as the context in which the relationship occurs. Additionally, how these factors are interpreted within the therapy relationship, much like the therapy outcome itself, is determined in part by the perspective of the observer. Hubble, Duncan, Miller, and Wampold (2010) expressed the impact of common factors on the therapy process in this way: "The eventual form a treatment assumes is thus entirely dependent on the materials available; the skills of the artisan; and most important, the desires and preferences of the end user" (p. 34).

As greater understanding of the role common factors play in the therapy process has been gained, more attention has been paid to the therapeutic relationship. However, much of this research still overlooks issues of diversity such as gender, race/ethnicity, and sexual orientation, and how they may impact therapist variables and client

perceptions. To gain a better understanding of this gap, it is important to first review the existing research on the therapeutic relationship and how diversity has been previously addressed in this line of inquiry.

Therapeutic Relationship

The therapeutic relationship between client and therapist accounts for the largest contribution to outcome in the common factors (Lambert & Barley, 2002). The therapeutic relationship is defined as "the feelings and attitudes that therapist and client have toward one another and the manner in which these are expressed" (Gelso & Carter, 1985, p. 159). This definition includes different aspects of the therapeutic relationship identified by researchers, such as the therapeutic alliance or collaborative relationship in which therapist and client work toward mutual goals (Horvath, 2001). This definition is also widely accepted in the field and was used by the Task Force on Evidence-Based Therapy Relationships (Norcross & Wampold, 2011). Evidence of the power of the therapeutic relationship has been reported in over 1,000 studies (Orlinsky, Ronnestad, & Willutzki, 2004). The importance of the therapeutic relationship has been a cornerstone of psychotherapy theory and practice since the very beginning. Early in the development of his clinical work, Freud emphasized the critical nature of this relationship in the form of transference and countertransference in his patients and collaborating with the ego to bring about a talking cure (Freud, 1940). Fraser and Solovey (2007) point out that the therapeutic relationship itself may be considered an intervention that is employed across all models of therapy and one that, when used effectively, decreases demoralization and engenders hope in clients.

Horvath and Bedi (2002) reported that, regardless of what each individual brings to the psychotherapy encounter, it is how he or she interacts and the relationship that is formed that is paramount. They further describe the alliance between therapist and client as the quality and strength of the therapeutic relationship and include positive bonds such as respect, mutual trust, caring, and liking one another (Horvath & Bedi, 2002). Horvath and Bedi (2002) also described goal consensus, both therapist and client commitment to their roles in the process of therapy, and belief in the commitment of one another as key elements of the therapeutic alliance.

A growing body of research has demonstrated the impact of the therapeutic relationship on therapy outcome. The client/therapist relationship has also shown to be the most influential variable in terms of psychotherapy outcome, with three to five times the amount of change attributed to it than specific therapy techniques (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011; Wampold, 2001). Bachelor and Horvath (1999) noted that clients' evaluations of the relationship were better predictors of outcome than therapists' evaluations. The therapeutic alliance has even been shown to predict outcome across different models of psychotherapy, including pharmacotherapy, and with both adults and children (Horvath, Del Re, Fluckiger, & Symonds, 2011; Hubble, et al., 2010).

Client/therapist relationship formation at the very start of psychotherapy and the therapist's ability to form a positive alliance have been shown to be predictive of outcome (Baldwin, Wampold, & Imel, 2007). Fitzpatrick, Janzen, Chamodraka, and Park (2006) found that, when clients interpret critical events occurring early in therapy as positive, they increased their openness to exploration. They reported this openness

manifested in greater client self-disclosure and an increased tendency to make use of input. These results were also associated with more positive feelings toward the therapist. Additionally, Westra, Aviram, Conners, Kertes, and Ahmed (2011) found that greater early therapist positive reaction to clients, especially liking, enjoyment, and positive attachment, were linked with significantly less client resistance.

Hubble, Duncan, Miller, and Wampold (2010) pointed out the research on the therapeutic relationship emphasizes the importance of the therapist's role in developing a positive, meaningful relationship by not only meeting the client where he/she is, but also by soliciting feedback from the client regarding the therapy experience. Fuertes, et al. (2006) reported finding that, for therapists, the perception of a strong therapeutic alliance with clients and feeling that clients experience them as competent correspond to higher overall work satisfaction. Kottler and Hunter (2010) noted how the therapeutic encounter can impact and instigate profound change in the therapist as well as the client. The most recent findings on evidence-based therapy relationships echo this idea of adapting therapy to clients and highlight the need to integrate treatment methods, therapy relationships, therapist qualities, and client characteristics and diagnoses in order to achieve the most effective outcomes (Norcross & Lambert, 2011; Norcross & Wampold, 2011a).

Several client variables have been shown to impact the formation and development of the therapeutic relationship. Paivio and Bahr (1998) found that clients who displayed attitudes of self-loathing and self-rejection had more difficulty forming a therapeutic relationship than clients who had positive beliefs about themselves. Zuroff, Blatt, Sotsky, Krupnick, Martin, Sanislow, and Simmens (2000) reported that high levels

of perfectionism interfered with clients' ability to have a positive therapy alliance. Not surprisingly, a number of studies found that client patterns of problematic interpersonal interactions had a negative impact on the development of the therapeutic relationship (Beretta, de Roten, Stigler, Fischer, Despland, & Drapeau, 2005; Constantino & Smith-Hansen, 2008; Nevo, 2002; Puschner, Bauer, Horowitz, & Kordy, 2005; Stiles, et al., 2004). Poor object relations, negative attachment styles, and dysfunctional relationships with parents have also been associated with problems developing positive therapy alliances (Eames & Roth, 2000; Goldman & Anderson, 2005; Hilliard, Henry, & Strupp, 2000; Kokotovic & Tracey, 1990). Constantino, et al. (2010), however, stated that all of these difficult interpersonal patterns may be overcome by adapting appropriately to the individual client's presentation.

A number of studies have shown certain therapist behaviors and skills to be influential in the development of a positive therapeutic relationship. Ackerman and Hilsenroth (2003) found several therapist attributes and behaviors conducive to building a positive relationship with clients. The attributes included respectfulness, interest, openness, flexibility, warmth, trustworthiness, honesty, and confidence. They reported the following behaviors as helpful in forming a positive working alliance in therapy: attending to clients' experience, reflection, accurate interpretation, exploration, and facilitation of affect expression (Ackerman & Hilsenroth, 2003). Previous research has also identified involvement, empathy, patience, acceptance, and support as relationship enhancing therapist attributes (Lietaer, 1992; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Watson & Greenberg, 1994). Henry and Strupp (1994) reported positive therapy relationships were associated with therapists being autonomy granting,

affiliative, guiding, and noncontrolling. De La Ronde and Swann (1993) pointed out the need to provide clients with verifying and accurate feedback in order to create an atmosphere conducive to positive change.

Hilsenroth and Cromer (2007) emphasized the need for therapists to be especially aware of the therapeutic relationship at the earliest stage of therapy, which they argued was the best opportunity to form a positive relationship and shapes how the relationship develops over the course of treatment. They demonstrated that a strong therapeutic alliance may be developed in the initial sessions--and even through pretreatment consultation--when the therapist conveys support, empathy, confident collaboration, exploration, activity, warmth, competence, active listening, respect, understanding, and nonjudgment. This seems to highlight the need for therapists to employ the above mentioned relationship-facilitating behaviors and stances during the initial assessment or first therapy session.

After conducting series of meta-analyses of all available research on elements of the therapeutic relationship, the second APA Interdivisional Task Force on Evidence-Based Therapy Relationships identified a number of elements found to fit into one of three categories: demonstrably effective, probably effective, and promising but insufficient research to judge (Norcross & Wampold, 2011). The relationship elements judged to be demonstrably effective were the alliance between therapist and client(s), cohesion in group therapy, empathy, and collecting client feedback. The elements found to be probably effective were goal consensus, collaboration, and positive regard. Those elements that fell into the promising but insufficient research to judge were congruence/genuineness, repairing alliance ruptures, and managing countertransference.

The task force also examined methods of adapting the therapeutic relationship to client characteristics and found the following methods of adapting to be demonstrably effective: reactance/resistance level, preferences, culture, and religion and spirituality (Norcross & Wampold, 2011b). Stages of change and coping style were methods found to be probably effective, and expectations and attachment style emerged as promising but insufficient research to judge.

In reporting the findings of the task force, Norcross and Wampold (2011) also mentioned that there are a number of elements previously identified by researchers as ineffective or damaging to the therapeutic relationship. These are all negative therapist behaviors; and they include negative processes, which encompass hostile, critical, pejorative, and blaming stances (Binder & Strupp, 1997; Lambert & Barley, 2002); using a confrontational style (Miller, Wilbourne, & Hettema, 2003); making unverified assumptions (Lambert & Shimokawa, 2011); therapist rigidity; inappropriate self-disclosure; criticalness; over-structuring of sessions (Ackerman & Hilsenroth, 2001); therapist-centered observational perspective (Orlinsky, Ronnestad, & Willutzki, 2004); and employing a one-size-fits-all approach to all clients (Norcross & Wampold, 2011). Previous studies have also stressed the importance of therapists' personal insights into their own family relationships, negative beliefs, and interpersonal patterns, as these factors have been found to have a significant impact on client relationships (Constantino, et al., 2010; Henry, et al., 1990; Henry & Strupp, 1994; Hilliard, et al., 2000).

Another area of the therapeutic relationship that has been studied is relationship repairs following ruptures or negative events. Burns (1990) and Burns and Auerbach (1996) emphasized the need for therapists to lead the way in repair attempts and invite

clients to discuss any negative thoughts or feelings in order to create a safe space to explore relationship difficulties. They also stressed the importance of the therapist's accurate expression of empathy, acknowledgement, and inquiry into client's experience of the relationship as a way of helping the client feel respected, validated, understood (Burns, 1990; Burns & Auerbach, 1996). Some more recent studies have suggested that exploration of both the therapist's and client's experience of the therapeutic relationship can be reparative in terms of relationship ruptures (Muran, 2009; Safran & Muran, 1996)

To date, research on the therapeutic relationship has focused mainly on the quality of the relationship and its impact on client outcomes. In these quantitative studies, the quality of the therapeutic relationship has typically been evaluated using some theoretically driven measure of therapeutic alliance variables rather than the subjective experience of client or therapist.

The nature and role of the therapeutic relationship has been examined in several qualitative studies, the majority of which have provided further evidence supporting prior empirical findings regarding the importance of the client perception of the relationship in the psychotherapy encounter (Maione & Chenail, 1999; Ward, Linville, & Rozen, 2007). These qualitative studies have identified integral components of a positive therapeutic relationship based on participants' experiences in the therapy process. These include therapist characteristics such as empathy, caring, acceptance, competence, support, and being personable (Bischoff & McBride, 1996; Kuehl, Newfield, & Joanning, 1990; McCollum & Trepper, 1995). Howe (1996) also described the impact of being understood as well as understanding and being engaged in the process of therapy as strong determinants of the therapeutic relationship. None of these studies, however,

addressed the therapeutic relationship across cultural variables such as race/ethnicity, gender, age, and sexual orientation.

In a classic study exploring clients' phenomenological perceptions of the therapeutic alliance, Bachelor (1995) identified three types of alliances. She labeled these the nurturant alliance, which emphasized therapist facilitative attitudes; the insight-oriented alliance, which emphasized client self-improvement; and the collaborative alliance, which was characterized by client self-involvement. Similarly, in a 2007 study of client perceptions of the therapeutic relationship with various different mental health providers, Shattell, Starr and Thomas described three types of relationships they labeled "relate to me," "know me as a person," and "get to the solution." In an earlier study, Bachelor (1988) also identified different types of empathy as perceived by therapy clients, deconstructing the traditional notion of one singular model of empathy. Although these studies seem to identify important client perceptions, they do not examine the impact of cultural diversity on client perceptions.

Additional qualitative studies of client experiences have deepened the understanding of therapist behaviors on clients. Knox, Hess, Petersen, and Hill (1997) examined the impact of therapist self-disclosure on clients and found that clients generally viewed self-disclosure by the therapist as contributing to the relationship. In a meta-analysis of seven different qualitative studies exploring client-identified helpful events in psychotherapy, Timulak (2007) found nine categories of impact of helpful events. These categories of impact were awareness/insight/self-understanding, behavioral change/problem solution, empowerment, relief, exploring feelings/emotional experiencing, feeling understood, client involvement, reassurance/support/safety, and

personal contact. Rhodes, Hill, Thompson, and Elliott (1994) looked at misunderstandings in therapy. They reported that therapists' unwillingness to discuss negative client reactions led to problems in the relationship and premature termination, whereas clients' willingness to bring up negative feelings about being misunderstood contributed to resolution. In a qualitative study of 14 therapists identified by peers as compassionate, Vivino, Thompson, Hill, and Ladany (2009) found that the following factors facilitated compassion in psychotherapy: therapists understanding client dynamics, therapists feeling clients' suffering, therapists identifying with and liking clients, client involvement, and a good therapeutic relationship.

A number of qualitative researchers have sought to examine methods to enhance the therapeutic relationship through interviews and discussions with both clients and therapists about the therapeutic process. Therapist-client "debriefing" or interviewing about the therapy process, in-session process evaluations, and interviews about client expectations were all found to enhance the therapeutic relationship (Bischoff, McKeel, Moon, & Sprenkle, 1996; Joanides, Brigham, & Joanning, 1997; Shilts, Rambo, & Hernandez, 1997; Todd, Joanning, Enders, Mutchler, & Thomas, 1990). In a study exploring both therapist and client perspectives on helpful events in therapy, Metcalf, Thomas, Duncan, Miller and Hubble (1996) found that, although therapists were more likely to attribute positive outcomes to therapy specific techniques, clients attributed positive outcomes to relationship factors.

Despite the important work done to identify the common factors and their contributions to psychotherapy outcomes, an integral piece of the therapeutic relationship has not been adequately addressed. It seems clear that common factors reach across

therapeutic orientations, but there is a noticeable absence of research exploring whether the common factors impact all clients and therapists in the same way. Several researchers promoting a common factors approach to psychotherapy highlight the need to engage clients as individuals rather than disorders (Bohart & Tallman, 1999; Lambert & Barley, 2002). Some research has suggested client variables such as education and psychological mindedness may impact the development of the therapeutic relationship (Marmar, Weiss, & Gaston, 1989; Orlinsky, Grawe, & Parks, 1994), however, other aspects of the individual client and therapist, such as issues of cultural diversity, have not been examined. There is little understanding of how the diverse and multiple identities that make up each client and therapist impact perceptions within the therapy encounter and the development of the therapeutic relationship. The existing research on cross-cultural relationships in psychotherapy is reviewed next.

Cross-Cultural Relationships

An important question remains regarding the impact of cross-cultural differences on the therapeutic relationship. Despite the recent emphasis on multicultural awareness and competency in psychotherapy, there has been little research on the experiences of the therapeutic relationship in cross-cultural counseling relationships. The study of cross-cultural differences in psychotherapy is especially important because, as Vasquez (2007) noted, "The reality is that, given the sociopolitical context in which people exist, they are all influenced by racism, ethnocentrism, sexism, heterosexism, and other *–isms* whether they are conscious of those or not" (p. 882).

The term cross-cultural, as used here, is defined as salient (to client, therapist, or both) differences in individual characteristics or cultural identities between client and therapist. These differences include, but are not limited to, gender, age, race/ethnic background, sexual orientation, and religious affiliation. On the micro-level, it can accurately be said that every therapeutic encounter between client and therapist represents a cross-cultural relationship. Nezu (2010) contended that any difference, especially one that was present during an individual's development, is a potentially important aspect of that person's identity. He also argued that certain differences are inherently culturally bound and exist in a historical context; therefore, they may have greater influence in an individual's everyday life and interpersonal relationships (Nezu, 2010). Greene (2007) pointed out that each individual has multiple overlapping identities and any given dimension of a person's identity may be more or less salient depending on the context of the situation and the individual's developmental stage. She also emphasized that individuals who are members of more than one socially disadvantaged group have mostly been ignored by psychotherapy research overall as well as specific areas of multicultural research in particular (Greene, 2007). For the purposes of this study, the cross-cultural differences examined will be limited to the five multicultural domains listed above.

All clinicians work with members of these groups, so it is important to develop multicultural competence and guidelines for best practices. Sue and Lam (2002) discussed the idea of adapting or customizing the therapeutic relationship for historically oppressed and underrepresented groups, including women, people of color, lesbian/gay/bisexual/transgendered (LGBT) individuals, and individuals from lower

socioeconomic status (SES; Lam & Sue, 2001). Comas-Diaz (2006) pointed out that cross-cultural relationships are often fraught with missed empathic opportunities and pointed out that these therapy encounters require special attention to cultural issues while also focusing on the client's individual needs. She also recommended modifying the therapy relationship to the client's culture, working to understand the client's voice, development of trust and credibility, as well as demonstrating cultural empathy (Comas-Diaz, 2006). Quinones (2007) stressed the need for therapists to "search and explore the meaning of differences and the ways they manifest in the client's behavior, worldview, relationships, and in the therapeutic relationship" (p. 166).

Constantino, Castonguay, Zack, and DeGeorge (2010), in a review of research on the impact of demographic variables on the formation of the therapeutic relationship with adolescents, suggested that therapists explore and make explicit differences such as gender, age, and ethnicity early in the therapy process in order to build the therapeutic relationship. In a study of 51 psychotherapy dyads, Fuertes, et al. (2006) found a strong positive association between clients' perceptions of their therapists' multicultural competence and ratings of the therapeutic alliance, including feeling understood and experiencing a trusting bond with their therapists. The same study also found that therapists' self-ratings on multicultural competence were significantly higher than their clients' ratings of them.

Some studies have suggested a relationship between improved therapeutic alliance and client-therapist matching on age, religious beliefs, and values (Hersoug, Hoglend, Monsen, & Havik, 2001; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983), though the evidence is mixed for matching on ethnicity (Farsimadan,

Draghi-Lorenz, & Ellis, 2007; Fuertes, et al., 2006; Ricker, Nystul, & Waldo, 1999). This seems consistent with the findings and practice recommendations of the Task Force in Evidence-Based Therapy Relationships that emphasized adapting therapy relationships to client characteristics (Norcross & Wampold, 2011).

The APA has issued psychotherapy guidelines for working with girls and women (APA, 2007; APA, 1978), people of color (APA, 2003), and LGBT individuals (APA, 2000); and the APA ethics code (APA, 2002) calls for clinicians to be sensitive to SES, age, and the religious diversity of psychotherapy clients. Others have also published guidelines and strategies for working with diversity in clinical practice (CNPAEMI, 2009; Hays, 2001) and examining cultural processes in the therapeutic relationship (Owen, Leach, Wampold, & Rodolfa, 2011). These guidelines, however, are typically quite global and fail to put forth any specific processes or interventions to be used in psychotherapy (Sue & Lam, 2002). Additionally, one national study of 149 practicing psychologists found that respondents did not follow recommended multicultural competencies and instead placed much greater value on personal and professional experience rather than guidelines and codes (Downing Hansen, Randazzo, Schwartz, Marshall, Kalis, Frazier, Burke, Kershner-Rice, & Norvig, 2006). There is far less research available on the psychotherapy process and outcome with diverse groups, including the impact of culture and differences on the therapeutic relationship (Roysicar, Hubbell, & Gard, 2003). Some studies have suggested that adapting existing therapy approaches to specific cultural groups can be an effective strategy (Griner & Smith, 2006; Sue, Zane, Nagayama Hall, & Berger, 2009); however, as Owen, et al. (2010) pointed out, these studies fail to distinguish the effects of the treatment model from the therapist

variables and the therapist's adherence to the model. This is a critical gap considering that even the most tolerant and antiracist individuals often hold implicit biases of which they may not even be aware (Kelly & Roeddert, 2008). It is also important to note that, in addition to the client's diversity status, it is essential to be aware of the therapist's diversity status and multiple identities and how they may impact the therapy relationship (Gelso, 2010). Muran (2007) stated that the therapeutic relationship can be viewed as an ongoing intersubjective negotiation between the various identities of the client and therapist, in which differences such as race, culture, sexual orientation, and gender are integral to the negotiation process.

Qualitative research has been identified as a particularly effective and important way to study the experiences of multicultural counseling clients (Morrow, Rakhsha, & Castañeda, 2001). The various and diverse research methodologies subsumed under the umbrella of qualitative inquiry have a number of advantages not available to the traditional quantitative research paradigm. These include the use of contextual information about the phenomena being explored, in order to gain a greater understanding of the subjective experiences of participants whose voices may be lost in statistics or dismissed as insignificant outliers in quantitative methods.

Sue and Lam (2002) posed three questions in their review of psychotherapy outcomes with minority populations. They explored whether psychotherapy has been found to be effective with each group; whether treatment outcomes are improved with population-specific or culturally specific therapy strategies; and whether client/therapist matching along group variables has any effect on therapy outcomes. These questions get to the heart of multicultural counseling by addressing the role of common factors in

psychotherapy with historically oppressed and underrepresented people. It is important to examine what the current body of research in these areas has shown and how the therapeutic relationship may be impacted by cultural differences and/or similarities. The following sections will provide an overview of existing research regarding psychotherapy efficacy, population-specific treatment techniques, and the impact of client/therapist matching in the therapeutic relationship with women, people of color, LGBT individuals, people from different socioeconomic classes, and people with strong religious or spiritual preferences, as well as various intersections of these identities.

Psychotherapy Research with Women

Existing empirical research has shown some contradictory evidence regarding differences in psychotherapy outcomes for women and men (Orlinsky & Howard, 1980). In an extensive review of client gender effects in psychotherapy, Garfield (1994) found no significant differences between men and women in therapy outcomes or premature termination. Talley, Butcher, Maguire, and Pinkerton (1992), however, did find a significant effect for gender, finding that women had better outcomes than men in a university counseling center.

In a study examining gender outcomes and type of short-term psychotherapy, Ogrodniczuk, Piper, Joyce, and McCallum (2001) reported that female clients had better outcomes in a more supportive type of therapy model, whereas male clients showed better outcomes when engaged in a more interpretive therapy model. A follow-up study using short-term supportive and interpretive mixed gender group interventions found that female clients had better overall outcomes in group therapy than males, regardless of type

of group (Ogrodniczuk, Piper, & Joyce, 2004). This is similar to Sikkema, Hansen, Kochman, Tate, and Difranceisco (2004), who also found that female clients achieved better overall group psychotherapy outcomes than men.

Several other psychotherapy outcome studies have found interaction effects with gender. It should be noted, however, that in discussing psychotherapy outcome research around gender, one difficulty noted by Levant and Silverstein (2006) is that in the field of gender studies, a theoretical shift has occurred over the past 25 years. As the gender studies field has moved away from defining gender as a biologically based trait and toward a socially constructed definition of gender, psychotherapy research has largely failed to keep up with this paradigm shift. Levant and Silverstein (2006) also argued that psychotherapy research on gender is flawed because it has ignored the contributions of feminist theory as well as the concept of the gender strain paradigm, which states that psychological stress and strain are generated by pressure to conform to traditional gender roles.

Orlinsky and Howard (1976) found that gender and age related to more positive outcomes, as younger female clients reported greater satisfaction with female therapists. They also found that female clients diagnosed with depression reported greater satisfaction with female therapists (Orlinsky & Howard, 1976). In a study examining gender and ethnicity, Fujino, Okazaki, and Young (1994) reported that Asian American women were less likely to drop out of therapy when matched with female therapists, and this effect was even more significant when matched by gender and ethnicity. The same study found that Asian American men had more sessions and less outcome symptomatology when matched by ethnicity, and less symptomatology when matched by

ethnicity and gender, while ethnicity and gender matching for White women was related to more sessions and lower drop out rates. White men showed no difference in outcome when matched by either gender or ethnicity (Fujino, et al., 1994). Bryan, et al. (2004) reported a disturbing gender by ethnicity interaction, where both male and female therapists rated non-White clients as more distressed than female therapists, even though non-White clients perceived themselves to be less distressed when working with male therapists. Hill (1975) found that more experienced female therapists were described as more empathic and facilitative than less experienced female therapists, while experience seemed to have the opposite correlation for male therapists. These results may indicate that client/therapist matching is related to psychotherapy outcome for female clients (Sue & Lam, 2002). The existing studies do not, however, provide further understanding of female clients' experience of having a female therapist, or how gender impacts the therapy relationship.

Culturally Specific Therapies with Women

There have been few empirical studies examining the effectiveness of feminist therapy or feminist therapy strategies with female clients. These existing studies have reported mixed results. Sirkin, Maxey, Ryan, French, and Clements (1988) found that both female and male clients in a day treatment program perceived some benefit from gender awareness therapy that emphasized the impact of gender on their mental health problems. In a study exploring the effect of a women's awareness group on women diagnosed with severe and persistent mental illness, Alyn and Becker (1984) found that women in the group reported an increase in self-esteem and sexual knowledge. Weitz

(1982) found that women, who participated in a consciousness-raising group employing feminist therapy techniques, displayed an overall decrease in depression symptoms and an increase in self-esteem. These results seem to show that interventions employing feminist therapy techniques are beneficial to female and male clients, but they do not demonstrate a superiority of feminist specific techniques with female clients.

In a study comparing the impact of feminist group therapy, feminist individual therapy, and a comparison group of generic individual therapy on battered women, Rinfret-Raynor and Cantin (1997) reported that each therapy was beneficial to clients, but no significant difference among therapy modalities was found. This appears to echo results found in the general psychotherapy outcome literature pointing to the importance of common factors, rather than specific techniques, in contributing to therapy outcomes. In order to examine how gender may influence the therapeutic relationship with female clients, some researchers have studied gender matching in the therapy dyad.

Client/Therapist Matching with Women

There have been mixed results regarding the effect of client/therapist matching on the gender variable. Zlotnick, Elkin, and Shea (1998) found that the gender of the therapist had no effect on outcome regardless of the gender of the client in a study using data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program. Similarly, LaSala (1997) found no significant gender or gender match differences in satisfaction with psychotherapy. Bryan, Dersch, Shumway, and Arredondo (2004) also reported that client perception of improvement was not related to gender of therapist. Four other studies, however, did find a significant effect for gender

matching. Furnham and Swami (2008) reported a significant gender effect, where individuals showed a preference for same gender therapists. Wintersteen, Mensinger, and Diamond (2005) reported adolescent girls in substance abuse treatment showed higher therapeutic alliance and retention when matched with female therapists, while boys paired with female therapists demonstrated lower therapeutic alliance and higher dropout rates. Jones, Krupnick, and Kerig (1987) found that therapy clients were more satisfied with female therapists than male therapists, and female clients with female therapists showed fewer symptoms at follow up. Interestingly, though, age accounted for a greater portion of outcome variance than gender in this study (Jones, et al., 1987). In another study, Jones and Zoppel (1982) found that female therapists were more likely than male therapists to rate female clients as showing improvement in therapy. They also found that female therapists were more likely to rate their clients as showing improvement and forming positive therapeutic alliances, regardless of gender. This is contrary to Warburton, Newberry, and Alexander (1989), who found female family therapists more likely to rate their clients with lower change and prognosis scores than male therapists. In a follow-up study, Jones and Zoppel (1982) found no relationship between gender match and therapy outcomes, but that gender matched clients were more likely to remain in treatment longer.

The current research suggests that women may have better overall psychotherapy outcomes than men and there is some evidence of an interaction effect between gender and ethnicity. There is very little research on culture-specific psychotherapy with women despite the emergence of feminist therapy as a distinct school of therapy over the past several decades. In addition, results have been mixed regarding client/therapist matching

with women in therapy. There remains, however, little research examining the actual experience of women in therapy, particularly in cross-cultural therapy relationships.

Psychotherapy Research with People of Color

The research on psychotherapy outcomes with people of color is limited; and the results are, at best, inconclusive (Sue & Lam, 2002). The term "people of color" here refers to the major ethnic groups in the U.S. currently: African Americans, American Indians, Asian Americans/ Pacific Islanders, and Latinos/as. Psychotherapy efficacy is rarely reported for people of color, and most outcome studies fail to disaggregate data by race/ethnicity (Fuertes, Costa, Mueller, & Hersh, 2005). The research regarding utilization of psychotherapy resources by people of color is mixed. Although some prior research has indicated that racial/ethnic minorities underutilize mental health services and drop out at higher rates (Casas, Vasquez, & Ruiz de Esparza, 2002; Department of Health and Human Services, 2001), a recent study by Chen and Rizzo (2010) using data from the Medical Expenditure Panel Survey from 1996-2006 showed no evidence of racial/ethnic disparities in use of psychotherapy services. Vasquez (2007) argued that more research is needed to assess the quality of the therapeutic relationship and how it affects therapy outcomes for people of color, as well as those factors that help to promote the therapeutic alliance in cross-cultural therapy.

A number of studies have found that White therapists, while quite comfortable addressing the impact their own ethnic, religious, and national identities have on their clinical work with clients, are often much less comfortable discussing race (Gushue & Constantine, 2007; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Utsey, Gernat,

& Hammar, 2005). Studies have also shown that skin color and facial features can have a negative impact on perceptions (Ahnallen, Syemoto, & Carter, 2006; Sherman & Clore, 2009). Additionally, van Ryn and Fu (2003) pointed out that race is typically ignored as a potential source of variability in treatment outcomes with people of color. Further, therapist race and ethnicity is often not reported in studies of cross-cultural counseling, making it quite difficult to distinguish which variables are indeed impacting therapy outcomes (Chang & Berk, 2009). Some studies have suggested the importance of client racial identity and cultural values in predicting help seeking behaviors and counseling processes, but very few have looked at how these factors impact actual therapy pairs (Atkinson & Lowe, 1995; Kim, Ng, & Ahn, 2005).

There is some compelling evidence that culturally adapted therapeutic interventions are effective and that interventions targeted to a specific cultural group are significantly more effective than more general interventions (Griner & Smith, 2006). Empirical support for ethnic matching in psychotherapy is inconclusive, and most studies suggest that client/therapist matching on ethnicity does not have a significant effect on outcome (Karlsson, 2005; Ricker, Nystul, & Waldo, 1999). In a study with over 100 ethnic minority clients in the United Kingdom, Farsimadan, Draghi-Lorenz, and Ellis (2007) found that clients in matched therapy pairs endorsed a stronger early bond with their therapists, but alliance quality mediated the relationship between ethnic matching and therapy outcome. Therapist variables such as multicultural sensitivity or multicultural competence may also have a great impact on ethnic matching, though there has been insufficient research on these variables (Fuertes, Bartolomeo, & Nichols, 2001;

Sue, 2003). This raises the question of how the development and experience of the therapeutic relationship might vary across cultural groups.

There has not been much qualitative research to date examining clients' experiences of ethnic differences in the therapeutic relationship. One study exploring clients' perceptions of cultural sensitivity in cross-cultural counseling (Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu, Bashshur, Codrington, & Liang, 2002) found that the choices and perceptions made by clients were in part based on their appraisal of the therapist's cultural competence and in part on how they experienced their own culture as having an impact on their presenting problems. In another study looking at cultural responsiveness in substance abuse treatment, Vandevelde, Vanderplasschen, and Broekaert (2003) found that clients expressed difficulty speaking emotionally about their culture and religion and reported that these two issues were strongly related to feelings of honor and respect.

More recently, Chang and Berk (2009) conducted a phenomenological, qualitative study examining clients' experiences of cross-racial therapy. After interviewing 16 clients of color who had engaged in psychotherapy with White therapists across a range of treatment settings, they found a number of therapist, client, and relationship factors that seemed to distinguish satisfied clients and unsatisfied clients. They reported that clients who were satisfied with their therapy experiences indicated their therapists adopted an active rather than passive role in therapy; disclosed personal information; and were viewed as caring, sensitive, and attentive. Chang and Berk also reported that satisfied clients perceived that racial/ethnic differences were irrelevant to their presenting problem and therapy goals and that there were significant benefits from working with a

racially different therapist. Satisfied clients in this study also seemed to compartmentalize race by acknowledging the impact of it in their personal lives but minimizing the effect on the therapy relationship, placed greater emphasis on shared aspects of identity with their therapists, reported that their concerns were adequately addressed by their therapists, and described their therapists as culturally responsive and skilled enough to work through misunderstandings related to race. Another interesting finding from this study was that all clients (both satisfied and dissatisfied) reported that therapeutic skills and the nature of the therapeutic task were more important than racial or ethnic differences in the therapy relationship.

The few psychotherapy efficacy studies examining African Americans seem to be contradictory. A number of studies (Jones, 1978; Jones, 1982; Lambert, et al., 2006; Lerner, 1972) found no significant differences in therapy outcomes between African American and White clients. Three other studies, however, found that African Americans had less favorable psychotherapy outcomes than Whites. Brown, Joe, and Thompson (1985) found that African American and Latino/a clients had poorer outcomes than White clients in a study examining drug treatment programs. Sue, Fujino, Hu, Takeuchi, and Zane (1991) reported that posttreatment symptomatology in African American clients was worse than in other ethnic groups. Finally, in a 2000 study, Markowitz, Spielman, Sullivan, and Fishman found that African American HIV-positive clients had worse outcomes than either Latinos/as or White clients in a depression treatment program. They also reported that African American clients in their study who received cognitive-behavioral therapy had less positive outcomes than African Americans receiving alternative types of therapy (Markowitz, et al., 2000).

The silence is deafening when it comes to psychotherapy outcome research with American Indians. One empirical study on American Indians in psychotherapy (Query, 1985) found that American Indian clients did not do as well as White clients in a substance abuse treatment program. A more recent study, however, reported that American Indian students receiving counseling services at a university counseling center demonstrated equivalent therapy outcomes when matched with similar White students receiving the same services (Lambert, et. al., 2006). Manson, Walker, and Kivlahan (1987) reported some earlier anecdotal evidence on the effectiveness of psychotherapy with American Indians, but they presented no empirical research results.

The limited psychotherapy efficacy research with Asian Americans seems to show no difference from Whites regarding psychological functioning in therapy outcomes (Sue, et al., 1991). Lee and Mixson (1995) and Zane (1983), however, found that Asian Americans reported lower satisfaction with treatment and progress in therapy than White clients. Wong, Beutler, and Zane (2007) also reported that Asian American clients tended to rate therapist credibility and therapeutic alliance as low due to a general unfamiliarity with the concept and process of counseling.

In their study of the Los Angeles County Mental Health System, Sue, et al. (1991) found that Latinos/as, specifically Mexican Americans, had better psychotherapy outcomes than other ethnic groups. Several other studies, however, have failed to demonstrate that Latinos/as benefit from most mainstream types of psychotherapy (Rosenthal, 2000).

Culturally Specific Therapies with People of Color

There is an extensive body literature devoted to developing culturally specific therapies and adapting existing therapy models in order to provide effective multiculturally competent psychotherapy to people of color. This literature has raised awareness of the importance of culture and produced several important guidelines for clinical practice, but it is primarily theoretical in nature and it does not address clients' experiences of cultural differences in psychotherapy. As Morales and Norcross (2010) stated, "Multiculturalism without strong research risks becoming an empty political value and EBP without cultural sensitivity risks irrelevancy" (p. 821). At present, there have been very few empirical studies examining culturally specific or culturally adapted therapies. However, those studies that have been reported suggest culturally adapted interventions provide some benefit to outcomes (Sue, et al., 2009). Lau (2006) argued that culturally adapted treatments should be used only in specific circumstances when client issues emerge within a distinct cultural context or when the client is a member of a group that has demonstrated a poor response to standard treatments in the past.

There are many suggestions and recommendations available for therapists regarding working with African American clients and adapting therapy models to fit Africentric cultural traditions and values. Longshore and Grills (2000) reported successfully adapting a motivational intervention for substance abuse treatment with African American adults based on traditional African American cultural values. Other researchers have reported success in adapting resilience-building and prevention programs for at-risk African American youth based on Africentric cultural values (Belgrave, 2002; Belgrave, Chase-Vaughn, Gray, Addison, Cherry, 2000; Harvey & Hill,

2004). At present, however, there are few empirical studies of psychotherapy outcomes for culturally specific therapy with African American clients. One study by Kohn, Oden, Munoz, Robinson, and Leavitt (2002) did report a greater decrease in depression symptoms in low-income African American women treated with a culturally adapted form of CBT compared to a similar group treated with a standardized nonadapted CBT protocol.

Few studies have explored the effectiveness of incorporating traditional practices and cultural values of American Indians and Alaska Natives in psychological treatment. De Coteau, Anderson, and Hope (2006) provided a framework for adapting manualized treatment of anxiety disorders to traditional American Indian cultural values. Gutierres, Russo, and Urbanski (1994) and Gutierres and Todd (1997) found that substance abuse treatment using traditions such as the sweat lodge and talking circle reduced depression symptoms and increased rates of program completion in American Indian clients, as opposed to standard nonculturally adaptive substance abuse treatment modalities. Interestingly, these studies did not report the effectiveness of the culture specific treatments on the primary issue of substance abuse.

Culture specific therapy studies with Asian American clients have often focused on issues of matching for language and ethnicity (Sue, Zane, & Young, 1994). There has also been some empirical evidence on preferred counseling styles with Asian Americans, suggesting they prefer more directive and problem-solving styles as these approaches are more congruent with Asian American cultural norms (Atkinson, Maruyama, & Matsui, 1978; Yuen & Tinsley, 1981).

There have been more empirical studies on culture-specific therapy modalities with Latinos/as than with other people of color. Culturally adapted forms of CBT and Interpersonal Process Therapy (IPT) have been shown to be successful with Latino clients (Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Rossello & Bernal, 1999; Rossello, Bernal, & Rivera-Medina, 2008). *Cuento* therapy, a culturally adapted child therapy incorporating traditional folk tales, has been found to be effective in reducing anxiety and aggression with Puerto Rican children (Constantino, Malgady, & Rogler, 1986, 1994; Malgady, Rogler, & Constantino, 1990). Szapocznik, Rio, Murray, Cohen, Scopetta, Rivas-Vazquez, Hervis, Posada, and Kurtines (1989) reported that the use of family therapy, which has been theorized to be more congruent with traditional Latino/a values, with Latino boys led to longer treatment durations and fewer premature terminations than individual therapy and a control group. Other successful interventions have also been culturally adapted for Latino clients using Spanish language translations, traditional culturally appropriate respect (*respeto*), and providing a more cultural context (Andres-Hyman, 2006). Additionally, Armengol (1999) reported success with a culturally adapted support group for Latino brain injury patients.

Although there is some evidence to support culture-specific therapies for people of color, the limited research conducted in this area is insufficient to demonstrate any superiority over more standard forms of psychotherapy. Furthermore, the few studies available do not address the experience of either clients or therapists engaged in culture-specific therapy. We do not know the impact of the culture-specific ingredients as compared to common factors or how culture may interact with additional client, therapist, or relationship factors.

Client/Therapist Matching with People of Color

The scant research on therapist-client matching along ethnicity has generally yielded mixed results. Casas, et al. (2002) suggested that most clients of color are more comfortable matched with therapists who are similar to them. Additionally, Sue (1998) stated that clients matched with therapists of similar ethnic background remain in treatment longer. Fuertes, et al. (2006), however, found no differences between cross-cultural client/therapist pairs and pairs matched on race/ethnicity on measures of therapeutic alliance, therapist empathy, therapist multicultural competence, therapist attractiveness, expertness, trustworthiness, and client satisfaction. Studies examining ethnic matching of African American clients and therapists have also yielded inconsistent results. Lerner (1972) found no difference in outcomes between African American and White clients when matched with White therapists. Two studies by Jones (1978, 1982) also reported no effect of ethnicity on psychotherapy outcomes. Sue, et al. (1991) found that ethnic match had a significant effect on number of therapy sessions; and Rosenheck, Fontana, and Cottrol (1995) reported that African American veterans had higher rates of early termination and fewer therapy sessions when paired with a White therapist. In a more recent study, however, Gamst, Dana, Der-Karabetian, and Kramer (2000) found that, at termination, African American clients matched with African American therapists had fewer treatment sessions and higher symptomatology ratings than those clients in unmatched therapy pairs.

In a qualitative study examining African American and White therapists' experiences in cross-cultural relationships, Knox, Burkard, Johnson, Suzuki, and Ponterotto (2003) found that African American therapists reported they regularly

addressed race with clients of color or when race was a central issue. White therapists, however, reported that they rarely addressed race unless clients initiated the discussion. This same study also found that, although both groups of therapists claimed discussions about race in cross-cultural therapeutic relationships were beneficial, African American therapists engaged in discussions about race due to perceived client discomfort, whereas White therapists expressed their own discomfort regarding discussions concerning race. In another qualitative study using interviews with White therapists working with African American clients, Fuertes, Mueller, Chauhan, Walker, and Ladany (2002) reported that beneficial therapist behaviors contributing to the therapeutic relationship included awareness and acknowledgement of issues of White privilege and White oppression.

Research exploring the effects of client/therapist matching with American Indians is also rare. Dauphinais, LaFromboise, and Rowe (1980) reported that trustworthiness was more important then ethnicity. LaFromboise and Dixon (1981) found no interaction between trustworthiness and ethnicity of counselor for American Indian high school students. Additional studies (Bennet & Bigfoot-Sipes, 1991; Havilland, Horswill, O'Connell, & Dynneson, 1983) have found correlations between ethnicity and client perception of effectiveness and client preferences, but they did not look at any direct outcome variables.

Client/therapist ethnic matching research with Asian Americans shows that ethnic matching resulted in a lower therapy dropout rate and increased length of treatment (Flaskerud & Hu, 1994; Fujino, et al., 1994; Gamst, et al., 2001; Lau & Zane, 2000; Sue, et al., 1991; Takeuchi, Sue, & Yeh, 1995). These two variables have been shown to correlate with positive treatment outcomes (Orlinsky, Grawe, & Parks, 1994). Sue, et al.

(1991) also found that ethnic and language matching could be an important outcome correlate for Asian American clients with limited English language skills. Additionally, Asian Americans who were low on acculturation seemed to do better with ethnically matched therapists (Sue, 1998).

Existing research on client/therapist matching suggests that Latino/a clients may benefit from being paired with Latino/a therapists. Sue, et al. (1991) and Takeuchi, et al. (1995) reported that ethnic matching correlated with positive therapy outcomes, fewer premature terminations, and greater length of treatment. This was especially true for ethnic- and language-matched therapy pairs. Flaskerud (1986) also found ethnic and language matching was related to fewer therapy dropouts for Latinos/as. Gamst, et al. (2000) reported that ethnic matching produced higher overall psychosocial functioning at termination for Latino/a clients. Finally, Sue (1998) found that Mexican American clients low on acculturation benefited more from ethnically matched therapists.

Another study using client interviews regarding perceptions of multicultural counseling experiences found that clients rated cultural competence as critical (Pope-Davis, Toporek, Ortega-Villalobos, Ligiero, Brittan-Powell, Liu, et al., 2002). This same study also revealed that clients were willing to forgive therapists' lack of cultural knowledge or sensitivity but were also more likely to blame themselves for their therapists' lack of understanding. As illustrated by the dearth of information and conflicting findings, researchers have only limited understanding of the effects of racial or ethnic responsiveness in cross-cultural therapy relationships (Ponterotto, Fuertes, & Chen, 2000).

The current research on psychotherapy with people of color is scant at best. There is some empirical evidence that people of color benefit from therapy, though this is an area typically ignored in the psychotherapy outcome literature. Although there is some support for culture-specific therapies for people of color, the research is limited and the few studies available do not address the experience of either clients or therapists engaged in culture-specific therapy. The minimal research on client/therapist matching with people of color has demonstrated that matching clients and therapists by race/ethnicity may lower dropout rates and improve outcomes. Overall, however, the experience of people of color in psychotherapy has largely been unexamined and there has been no research looking into how people of color experience cross-cultural therapy relationships.

Psychotherapy with Sexual Minorities

Empirical research examining psychotherapy efficacy with LGBT individuals is quite limited. As with other oppressed groups, there has been a longstanding distrust for the field of psychology and the practice of psychotherapy among the LGBT community, due in large part to the field's historical view of homosexuality as pathological, as well as the continued endorsement of conversion therapy in some circles (Jones, Botsko, & Gorman, 2003). As Perez, DeBord and Bieschke (2000) pointed out, however, LGBT individuals seek psychotherapy at rates double those of the heterosexual population. Until recently, the few studies addressing therapy outcomes with LGBT individuals focused on gay men involved in HIV risk-reduction treatment programs or bereavement groups (Dunkle, 1994); and, although these interventions demonstrated some efficacy,

they did nothing to address lesbian, bisexual, or transgendered therapy clients. Even the use of the acronym LGBT itself is somewhat problematic as it fails to capture the diversity of identities within the sexual minority population (Diamond, 2003).

Culturally Specific Therapies with Sexual Minorities

Gay affirmative therapies are those psychotherapy approaches that embrace and affirm LGBT individuals and their relationships for who and what they are without judgment or comparison to a heterosexist "norm" (Bieschke, McClanahan, Tozer, Grzegorek, & Park, 2000; Morrow, 2000). Although it seems self-evident that LGBT clients would benefit from therapy stances that validate rather than ignore or pathologize their identities, and anecdotal reports maintain the helpfulness of affirmative therapy, there is no empirical evidence supporting the effectiveness of LGBT affirmative psychotherapy (Perez, DeBord, & Bieschke, 2000). Additionally, Burckell and Goldfried (2006) found that LGBT clients reported that establishing a trusting, collaborative therapy relationship was more important than whether or not sexual orientation was the focus of therapy.

Client/Therapist Matching with Sexual Minorities

Studies examining client/therapist matching on sexual orientation have shown some effects of matching. This is a complex issue because it involves the therapist disclosing her/his sexual orientation to the client; and, as Fish (1997) pointed out, this may be best done on a case-by-case basis. In an early study, Liljestrand, Gerling, and Saliba (1978) reported that client/therapist matching related to better outcomes in dealing

with sexual orientation issues. Brooks (1981) found a significant difference in lesbian clients' perceptions of helpfulness based on therapist gender and sexual orientation. In this study, lesbian clients with heterosexual male therapists reported much worse experiences than those whose therapists were heterosexual women, lesbian women, or gay men. Similarly, Liddle (1996) reported that lesbian and gay clients perceived heterosexual male therapists and female therapists whose sexual orientation was unknown to be significantly less helpful than gay, lesbian, bisexual, or known heterosexual female therapists. In a large national study examining predictors of therapy outcome in lesbian, gay, and bisexual clients, Jones, et al. (2003) found that having a female, lesbian, gay, or bisexual therapist was associated with positive outcomes. Interestingly, this study also found that therapists' training as a social worker or psychologist predicted positive outcomes, as did an absence of conflicted feelings in the client regarding sexual orientation.

Very little empirical research has been done on psychotherapy outcomes with sexual minorities. This area of diversity often goes unreported in outcome studies. There is no existing empirical research examining gay-affirmative therapy. Some evidence suggests that LGBT individuals may have better therapy outcomes when matched with a female, lesbian, gay, or bisexual therapist. Information is still quite lacking regarding the experience of LGBT clients in psychotherapy despite evidence showing that LGBT individuals seek therapy at much higher rates than heterosexuals.

Psychotherapy Research on SES

SES is a difficult construct of diversity to study, in part because it is difficult to operationally define (Sue & Lam, 2002). SES is most commonly defined as a measure of an individual's position or standing in society based on education, income, and social status, and can determine things such as access to services, privilege, and relative power (APA, 2007; Williams & Rucker, 1996). The APA Task Force on Socioeconomic Status (2007) has called for a greater role of psychologists in raising awareness and taking action to address the expanding inequalities in SES in the U.S. and the accompanying disparities in healthcare outcomes.

Psychotherapy research examining the impact of SES, has primarily explored the effectiveness of therapy with individuals from lower SES backgrounds; but confounding interactions with other variables such as race, ethnicity, gender, and age make this a difficult area to study (APA, 2007; Lorion & Felner, 1986). Much of the multicultural competence literature focuses on other variables related to culture and addresses SES in more cursory manner, providing few clear guidelines regarding clinical work with low SES clients (Hopps & Liu, 2006; Liu, Soleck, Hopps, Dunston, & Picket (2004). Overall, there have been fewer studies on the effects of SES and social class on treatment outcomes than most other diversity variables (Sue & Lam, 2002). There is some evidence linking lower SES clients with higher dropout rates in psychotherapy (Reis & Brown, 1999; Wierzbicki & Pekarik, 1993), although Pekarik (1991) found client expectations regarding therapy to play a more significant role in outcome than SES.

Culturally Specific Therapy and SES

There is no research identifying therapy approaches specifically designed or adapted for clients from low SES backgrounds (Sue & Lam, 2002). Some evidence suggests that clients from lower SES backgrounds may prefer more directive approaches to psychotherapy over insight-oriented approaches (Goin, Yamamoto, & Silverman, 1965; Organista, Munoz, & Gonzalez, 1994; Satterfield, 1998). This may have relevant implications for the therapeutic relationship, though it may also reflect a general lack of time to devote to activities such as psychotherapy given the multiple financial, occupational, and social stressors associated with low SES.

Client/Therapist Matching on SES

There is no available research examining the matching of clients and therapist in terms of SES. This is a unique dilemma because, despite personal family of origin history, the very nature of psychologists' advanced education and social status serves to create distance between themselves and clients from lower SES backgrounds (APA, 2007).

As an area of diversity, SES has been excluded from most multicultural counseling research. This is in part due to the difficulty in establishing an operational definition of SES. There is no current empirical research exploring the experience of people in therapy relationships where SES is a factor.

Psychotherapy Research on Religious/Spiritually Oriented People

Approximately 95% of the U.S. population report they believe in God (Gallop, 1995), and most Americans identify with a specific religion; however, the relationship between religion and psychotherapy has historically been tense (Worthington & Aten, 2009). Most therapists identify themselves as significantly less religious than both the general population (Bergin & Jensen, 1990) and most of their psychotherapy clients (Delaney, Miller, & Bisono, 2007). Although a majority of therapists report positive attitudes toward spirituality and a general respect for a diversity of religious beliefs (Bergin & Jensen, 1990), they tend to assume that most other people endorse a nonreligious spirituality, much like they encounter with other members of the therapist community (Worthington & Aten, 2009). Formal clinical training in addressing religious issues in psychotherapy does not seem to be the norm (Richards & Bergin, 2000); however, there is evidence that 30%-90% of clinicians incorporate some spiritual interventions in their psychotherapy practices (Ball & Goodyear, 1991; Raphel, 2001; Richards & Potts, 1995; Shafranske, 2000). Growing awareness of the influence of values in psychotherapy led the APA to address the issue of religious diversity in the 1992 revision of the ethical code and in a more recent resolution on religion-based prejudice (APA, 2008).

Culturally Specific Therapies with Religious/Spiritually Oriented People

A number of established therapy models have been adapted for use with religious or spiritually oriented people. Spiritual psychotherapy interventions may include consulting with religious/spiritual leaders; incorporating religious concepts, texts, or

imagery; teaching and encouraging mindfulness or contemplative meditation; encouraging prayer; and assessing spiritual well-being (Richards & Bergin, 2005). A relatively small number of studies have found religiously accommodating manualized therapy models to be effective with religious clients (Post & Wade, 2009; Richards & Worthington, 2010). Propst (1980) and Propst, Ostrom, Watkins, Dean, and Mashburn (1992) found Christian-oriented cognitive behavioral therapy approaches to be more effective than standard nonreligious "secular" cognitive behavioral therapy. In a meta-analysis of Christian-oriented therapies, McCullough (1999) did not find any significant difference between Christian and secular therapy approaches. Azhar, Varma, and Dharap (1994) reported that Muslim clients diagnosed with anxiety disorders exhibited a significant decrease in anxiety symptoms after a Muslim-oriented therapy approach. Similar studies have indicated a significant decrease in symptomology of Muslim clients diagnosed with dysthymic disorder and major depressive disorder who received Muslim-oriented therapy (Azhar & Varma, 1995a; Azhar & Varma 1995b).

A number of outcome study reviews have concluded that there is support for Muslim and Christian adapted cognitive therapy models for anxiety and depression (Hook, Worthington, Davis, Jennings, Gartner, & Hook, 2010; McCullough, 1999; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis & McDaniel, 2011; Worthington, Kurusu, McCullough & Sanders, 1996; Worthington & Sandage, 2001). Hook, et al. (2010) also found some evidence to support the probable efficacy of additional spiritually oriented therapy models, including Christian devotional meditation for anxiety, Christian group therapy for issues around forgiveness, Christian cognitive-behavioral therapy (CBT) for marital issues, a Chinese Taoist oriented CBT for anxiety, a

Buddhist CBT model for anger, and a theistic spirituality group therapy for eating disorders. In a meta-analysis including the relatively few number of studies examining these religious-oriented approaches, however, it is still unclear to what extent the religion-specific aspects of the treatment were responsible for the therapy outcomes. Further quantitative and qualitative research is needed to identify what types of spiritually oriented therapies are effective, for whom, and how client and therapist variables impact spiritually oriented treatment approaches (Richards & Worthington, 2010).

Client/Therapist Matching with Religious/Spiritually Oriented People

At present, there is still very little empirical research examining the impact of religious differences in psychotherapy outcomes (Worthington & Sandage, 2002). There is no empirical research examining the impact of the therapist's religious beliefs on psychotherapy; however, highly religious clients have been found to perceive religious issues as a central aspect of counseling (Wyatt & Johnson, 1990) and also prefer therapists who are religiously similar to themselves (Keating & Fretz, 1990; Wikler, 1989; Worthington, Kurusu, McCullough, & Sandage, 1996; Worthington, & Berry, 2001). Ripley, Worthington, and Berry (2001) reported that clients who identify as highly religious may anticipate negative experiences in psychotherapy with a secular or nonreligious therapist; however, Pecnik and Epperson (1985) found that counselors who are described as religious tend to be perceived as less expert than counselors without this descriptor.

Some research indicates that individuals who identify themselves as religious or spiritually oriented benefit from psychotherapy. Examples of successfully adapted

religious oriented therapy are discussed in the psychotherapy literature; however, it is still unclear to what extent the religion-specific aspects of the treatment were responsible for the successful outcomes reported with these types of therapies. In addition, client/therapist matching along religious and spiritual beliefs has yielded mixed results. To date, no research studies have examined the lived experience of religious/spiritually oriented individuals involved in a cross-cultural therapy relationship.

The overall efficacy of psychotherapy has been demonstrated over the past several decades of empirical research. Although there remains some disagreement as to the essential curative factors of psychotherapy, the preponderance of existing evidence indicates that the common factors present across all therapeutic orientations and approaches account for a greater percentage of therapy outcomes than specific techniques. These common factors include therapist variables, facilitative conditions, and the therapeutic relationship. The therapeutic relationship is the foundation of all major schools of psychotherapy; and, although it has been studied extensively, there is little known about the experience of cross-cultural differences in the therapy dyad. The research in multicultural counseling provides extensive theoretical guidelines and anecdotal information regarding multicultural competence in clinical practice, but there is a lack of evidence as to what clients and therapists actually experience. The empirical evidence that is available is often conflicting and narrow in scope. In order to gain a better understanding of the dynamics of cross-cultural differences in the therapeutic relationship and inform future development of best practices, it is necessary to expand our knowledge of the lived experience of those who are currently engaged in the phenomenon of cross-cultural therapy.

The Therapeutic Relationship in Cross-Cultural Therapy

It has been shown that the therapeutic relationship plays a significant role in the psychotherapy process. The relationship is the most powerful component of therapy on which the therapist can have a direct impact. Most of the existing research on the therapeutic relationship, however, focuses on the issues of effectiveness, culture-specific techniques, and client/therapist matching. There is very little we know regarding how clients and therapists perceive their relationship within the therapy dyad or how this critical common factor works in the cross-cultural therapy situation. Although important theoretical concepts such as multicultural competence and cultural responsiveness are often well-defined and extensively discussed in the multicultural counseling literature, there remains a surprising lack of research exploring how they manifest in practice. Many of the studies conducted are based on potential clients or analogue situations rather than actual therapy encounters. Sue and Zane (2006) recommended that, in the notable absence of empirically identified models of treatment and therapeutic relationship strategies for cross-cultural psychotherapy, an intermediate goal of examining the therapeutic processes and phenomena is needed. Few studies have explored how client and therapist perceptions and experiences relate to the therapy process and outcome in real, cross-cultural therapy relationships (Chang & Berk, 2009). In addition, the Task Force on Evidence-Based Therapy Relationships has recommended that future research on the therapy relationship explore the contributions of both therapist and client to the relationship elements and address the observational perspectives of therapists and clients in the relationship (Norcross & Wampold, 2011). A true understanding of both client and therapist contributions and perspectives in the cross-cultural therapeutic relationship can

be reached only through qualitative inquiry into the lived experience of both relationship partners.

Purpose of the Study and Research Questions

The purpose of this study will be to describe the lived experience of both clients and therapists in a cross-cultural therapeutic relationship. At this stage in the research, the definition of the therapeutic relationship developed by Gelso and Carter (1985) will be used: "The relationship is the feelings and attitudes that therapist and client have toward one another and the manner in which these are expressed" (p. 159). Using this operational definition, the questions guiding the research are: 1) How do clients and therapists in a cross-cultural relationship (where client and therapist differ by race/ethnicity, gender, sexual orientation, religion, or other salient variables) perceive and experience the therapeutic relationship? and 2) How do these clients and therapists understand and make meaning of the impact of their cross-cultural differences on the therapeutic relationship?

Rationale for Qualitative Research

Although an enormous amount of theoretical writing and empirical research has been devoted to the therapeutic relationship, there is surprisingly little known about what the manner in which the psychotherapy participants experience this relationship and how their differences impact this relationship. To delve into the complexities and processes of the impact of cross-cultural differences on the therapeutic relationship, qualitative methodologies will best elicit tacit knowledge and subjective understandings and

interpretations. This type of research may be conducted with both clients and therapists currently engaged in an ongoing therapy encounter and may also best negotiate the complexities of gathering information regarding internal processes and lived experience.

Qualitative methods were selected for this investigation because of the need to use an inductive, exploratory approach to develop a clear understanding of the participants' experiences. Qualitative research methods can "more clearly capture the complexity and meaningfulness of human behavior and experience" (Morrow & Smith, 2000, p. 199). The intricacy of the meaning clients have made of their experiences is made possible by permitting more openness to findings and accessing participants' full descriptions of their realities (Miles & Huberman, 1994).

Finally, consistent with recommendations of the Task Force on Evidence-Based Therapy Relationships (Norcross & Wampold, 2011) regarding research attention to multiple interacting sources of scientific evidence/knowledge, there is a need for additional methodologies to be employed in the study of the complex associations among client qualities, therapist behaviors, and treatment outcome. The majority of research on the therapeutic relationship is based on quantitative methods examining therapy outcomes, and limited research of any type has been conducted on cross-cultural therapeutic relationships.

Traditional quantitative methodologies are not always the most respectful, effective, valid, or reliable methods to conduct multicultural research. Making greater use of a diversity of methods, including qualitative methodologies, is important for the future of multicultural psychotherapy research for a number of reasons. First, it allows client and therapist to define their own identities and the intersections of these identities

in the therapeutic relationship, rather than forcing a choice from preconceived categories. Second, qualitative research can further heighten the appreciation of client's agency and help unlock the power dynamics of the therapy relationship. Third, research relying on only quantitative methods often leads researchers to dismiss contextual or multicultural variables that could be meaningful mediators of the experiences of both clients and therapists. Finally, correlational methods presume the stability of individual differences and focus on these trait-like variables while overlooking important contextual meanings.

In sum, qualitative methodologies have rarely been utilized in the limited research on cross-cultural therapeutic relationships. Qualitative methods will be a crucial addition to future study of the experience of differences between client and therapist in psychotherapy. Findings from studies that do not rely on correlational measures or quantitative data may influence researchers to examine new kinds of research questions and allow for understanding of the subjective, lived experience of psychotherapy participants, resulting in new theoretical understandings of how clients and therapists make meaning from their relationship.

CHAPTER 2

METHOD

Research Paradigms

The majority of research in the social sciences, and psychology in particular, has been framed in the traditional positivist research paradigm (Ponterotto, 2005). The positivist research paradigm or worldview is based on the assumption of an objective truth, which can be discovered and understood by the use of classic quantitative reductionist methodologies similar to those employed by researchers in the physical sciences (e.g., chemistry, biology). There are problems, however, when imposing this paradigm on the study of human experience, which occurs in multiple, often intersecting, and occasionally contradictory contexts. The concept of an objective truth unequivocally endorses a single monolithic vision of Truth and consequently disregards, and at times stigmatizes, all other truths of lived experience. Traditionally, positivistic scientific inquiry has been the enforcer of objective truth. Due to the historic dominance of the positivist paradigm in scientific inquiry, positivist researchers have not had the need to explain or justify their worldview (Morrow, 1992). It is therefore the burden of researchers approaching knowledge and scientific inquiry from an alternative paradigm to necessarily articulate their worldview and the assumptions underlying their research methods.

This section will describe the core principles guiding this research study. The two overarching research paradigms informing this study were social constructionism and feminist theory. In order to better understand these two approaches to inquiry and their relevance to research on cross-cultural therapeutic relationships, it is helpful to have an overview of the major ontological, epistemological, and axiological perspectives they bring to the production of knowledge.

Social constructionism is guided by the premise that rejects the notion of a singular reality, or truth, and states that knowledge and meaning are socially derived. The ontological perspective of this paradigm is that reality is subjective and dependent upon the participants' various, often differing, viewpoints (Creswell, 2007; Morrow, 2007). Reality is constructed and interpreted through social, cultural, and historical lenses (Guba & Lincoln, 2008); and so it is essential to study participants' experiences from a contextual and relativistic stance. Epistemologically, social constructionism is subjectivist and transactional; thus, the researcher positions her/himself in a way as to collaborate with participants and co-create meaning (Creswell, 2007; Morrow, 2007).

The axiology of social constructionism refers to the role in which values, particularly the values of the researcher, impact the study (Denzin, 2005). Qualitative researchers acknowledge that all research is inherently value laden, but rather than attempt to control for this as in a positivist research paradigm, an emphasis is placed on the importance of maintaining awareness and transparency regarding values and potential biases (Morrow, 2007; Ponterotto, 2005). In social constructionism, it is assumed that the value biases of the researcher exist and could never be eliminated; therefore they are embraced and "bracketed" as a part of the research process (Ponterotto, 2005).

Consistent with this axiological position, the language or rhetorical structure of social constructionist research is typically more personal, including the voice of the researcher; subjective; and quite a bit less formal than traditional positivist studies (Morrow, 2007).

In addition to the social constructionist paradigm, this study also draws heavily on feminist and multicultural theory as positioned in the critical theory paradigm (Denzin, 2005; Morrow, 2007). Although there is no single critical theory framework, both feminist and multicultural qualitative research epistemologies place a primary emphasis on issues of power, oppression, and social justice, examining the impact of these realities in the sociopolitical context of historically oppressed groups (Kincheloe & McLaren, 2000; Morrow, Rahksha & Castañeda, 2001). Critical theory paradigms operate from an ontological stance of multiple realities; however, they conceptualize these constructed realities through the experiences of oppression and power relations (Ponterotto, 2005). Critical theories use a transactional epistemology in which researcher and participant engage in a dialectic process of creating meaning, while also emphasizing emancipation, egalitarian ideals, and empowerment of oppressed peoples (Denzin, 1994; Ponterotto, 2005; Tolman & Brydon-Miller, 2001). Critical theories, therefore, are unapologetic regarding the direct influence of social justice values (Morrow, 2007; Ponterotto, 2005).

The combination of these two paradigms best allowed for exploration and understanding of the lived experience of individuals engaged in a cross-cultural therapeutic relationship and how they co-created meaning in this intimate encounter, while acknowledging the sociopolitical context of their differences. It is my hope that this synthesis has also contributed to bridging the current gap between research and practice in multicultural counseling by encouraging both clients and therapists to gain a

deeper understanding of their therapy partners' experiences in an effort to develop a more empowering and egalitarian therapeutic relationship.

Research Design

In the continuing evolution of psychotherapy as a healing art, it is absolutely critical that all voices be heard and the experiences of all participants be acknowledged and understood. Qualitative research methodologies are best suited to explore the depth of individual experience and uncover meaning created by clients and therapists within their unique relationship. "Qualitative inquiry deals with human lived experience. It is the life-world as it is lived, felt, undergone, made sense of, and accomplished by human beings that is the object of study" (Schwandt, 2007, p.100).

The most important issue for me, in designing this study, was allowing the participants' raw experiences to emerge as the central focus. I wanted to acknowledge my own values and biases, and their potential impact on the study, but I did not want them to become barriers to understanding or overshadow the voices of participants. For this reason, I chose to use a phenomenological research design.

Moustakas (1994) relates that the word phenomenon comes from the Greek *phaenesthai*, meaning to flare up, to show itself, to appear. Phenomenology as a qualitative research method is devoted to examining and understanding the phenomenon of *being in the world* or to allow the lived experiences of human beings to reveal themselves. As a method of inquiry, phenomenology is based on the early 20th century work of philosopher Edmund Husserl, who in turn was heavily influenced by his predecessors in the fields of philosophy and psychology such as Rene Descartes,

Immanuel Kant, Franz Brentano, William James, and G. W. F. Hegel (Moustakas, 1994; Wertz, 2005).

Husserl's original method included four basic concepts that remain essential to modern existential and phenomenological studies (Wertz, 2005). The first of these concepts has to do with an unbiased psychological attitude of the researcher. Husserl described two procedures called *epochés*, meaning abstentions from influences that could potentially bias findings (Moustakas, 1994; Wertz, 2005). The first epoché is that of the natural sciences in which the researcher sets aside previous scientific assumptions, theories, and hypotheses. The second epoché requires the researcher to put aside or *bracket* her/his own beliefs about the world and the phenomena being examined. Together these two epochés or attempts to bracket previously held knowledge and beliefs allow us to experience the phenomena from the subjective vantage point of the persons involved, echoing Husserl's phrase, "To the things themselves!" (Wertz, 2005).

The second basic concept is known as the intuition of essences or the eidetic revolution, which refers to reducing the subject matter (phenomenon) to the essential qualities or essence of what it is (Wertz, 2005). It is important to note that this search for essential qualities should not be viewed as contradictory to a social constructionist frame. Phenomenological analysis honors both individual and social constructions of meaning, thus seeks to understand the essence of a phenomenon as it is construed by each individual who experiences it. As the phenomenon is reduced to its essence, it is also important to be aware of how it interacts with the world and impacts those who experience it in terms of feelings, thoughts, and meanings it may elicit. This is the third concept, known as intentional analysis (Moustakas, 1994).

Husserl's fourth concept is the lived world or *lifeworld* (Wertz, 2005). This lifeworld is defined as the everyday world in which we live that is socially shared and individually experienced by each of us (Giorgi, 2009; Wertz, 2005). The lifeworld encompasses both individual perception and collective or cultural subjectivity (Wertz, 2005).

Building on Husserl's conceptual framework, Amedeo Giorgi (2009) and Clark Moustakas (1994) are credited with developing current qualitative research procedures and methods using phenomenology (Wertz, 2005). Although there are some variations on phenomenological research methods, Giorgi (2009) asserted that the core characteristics are that the research is descriptive, employs reduction techniques (as described above), examines intentional relationships between person(s) and phenomena, and provides information about the essence of the phenomena. Wertz (2005) outlined the steps involved in phenomenological research. These are: 1) identifying the phenomenon and research problem; 2) developing data constitution, which includes identifying and recruiting participants, choosing the type of situation, and outlining procedures of description; 3) data analysis, which involves assuming the appropriate attitude via bracketing, analyzing individual descriptions, and grasping general structures; and 4) presentation of research results that may include the impact on the field, practical implications, and the impact of the study on participants (Wertz, 2005). Within this overall context, Giorgi (2009) listed the key methodological steps for analyzing phenomenological data as reading for a sense of the whole, determining meaning units, and transforming participants' natural attitude expressions into phenomenologically sensitive expressions.

Phenomenology was the most appropriate design for this study as it embraces multiple perspectives and seeks to understand experiences as they are lived and felt by individuals in the cross-cultural therapeutic relationship, regardless of prior assumptions. Wertz (2005) described the humble stance and empowering nature of this design as "a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known" (p.175).

Researcher as Instrument

Qualitative research acknowledges that all research is subjective and influenced to some degree by the researcher; therefore, the worldview of the researcher is explicitly described as a method of establishing rigor and trustworthiness (Morrow, 2005). By embracing our subjectivity and value biases and making them transparent, we as researchers are better able to monitor the impact of our worldviews on research participants, data collection, and analysis. Whereas in quantitative research methods, the goal is to remove the researcher from the design using various experimental controls and objective assessment instruments, in qualitative inquiry, the researcher is the key instrument (Creswell, 2007). An essential concept in examining the researcher as instrument is reflexivity; the critical reflection of self and one's own identities and how they shape the research process (Guba & Lincoln, 2008).

In phenomenological design, the researcher identifies her/his worldview and social position, then brackets these personal biases using Husserl's epochés as mentioned above, in order to obtain a natural, more naïve view of the phenomena under

investigation (Wertz, 2005). This is consistent with the social constructionist paradigm in that the researcher remains mindful of the multiple realities of participants and, in an attempt to enter into those realities, fully explores and sets aside her/his own personal lens, while acknowledging that the data analysis and description will ultimately be a socially constructed whole. Similarly, the critical theory paradigm seeks to empower participants by honoring and celebrating diverse multicultural realities, while acknowledging and balancing the power and privilege of the researcher in an effort to create an egalitarian process in which the seeds of social change take root.

In this section, I first describe myself and my own intersecting identities and explore how they may have impacted this study. I then outline the methods I used in order to bracket my biases, achieve reflexivity, and allow the participants' lived experiences to remain the primary focus.

I am a 43-year-old, White, progressive, heterosexual, married, male graduate student, who was raised in a lower-middle class family and identifies as Roman Catholic. Although I believe there is more to who I am than I could accurately convey in one sentence, this encapsulates my sociocultural positioning.

As a White man, my race has not always been as personally salient to my own sense of self as my gender. This being said, I acknowledge my own whiteness and the enormous privilege that has come along with it. It has been over 10 years since I was first introduced to the ideas of whiteness and White privilege; and, in that time, I believe I have grown through many stages of defensiveness, denial, guilt, and acceptance of myself as a White man working toward positive social change in a racist society which grants me some degree of privilege over others.

Gender has always been a significant factor in my life. I was raised by a single mother who worked long hours to provide for me, as well as two loving grandmothers who helped immeasurably. There was no man in our home, and so the gender roles I witnessed in other families and in the media did not resemble my home experience. This presented some problems as I grew older and encountered different expectations regarding what it meant to be a man in society and how men should interact with women. I acknowledge my privileged position as a male in a gendered society, as well as the power and limitations that come with it.

My attitudes around sexual orientation and homophobia have been much slower in evolving. The experience of being raised by women without a traditional male role model, although liberating in some ways, caused a great amount of angst and confusion as well. I can recall feeling a need to relearn certain things and adapt my behavior in an effort to fit in with male peers so as not to be seen as less masculine, which was equated with being homosexual. Being heterosexual, and feeling the need to act in a certain way to prove it to others, also meant continuously demonizing homosexuality and internalizing homophobia and heterosexism. As an adult, I have been confronted with my own heterosexist attitudes and behaviors. I have also become increasingly more aware of their presence in family members and friends. I feel that I have come a long way in shedding my internalized biases regarding sexual orientation and I am very sensitive to the hateful attitudes I recall endorsing, whenever I witness them in others.

I credit my religious beliefs as a Roman Catholic, along with the basic liberal values with which I was brought up, as setting the foundation for my personal growth. I was, and continue to be, strongly influenced by the social justice agenda within the

Catholic Church. I am also an independent, critical thinking, humanist who acknowledges the reality of multiple truths and refuses to endorse the hypocrisy and injustice in many of my church's official positions on various issues. Although this may appear inconsistent and a bit naive, I can say that I believe my church will inevitably progress and adapt to become more inclusive and accepting, with the help of people like me, though perhaps not as quickly as many of us would hope. In conducting this study, I feel it is important to acknowledge my own personal belief system as well as my deep respect for the truth and richness of other belief systems, whether they are religious, spiritual, scientific, or none of the above.

Growing up in a position of unearned privilege, often exposed to racist, sexist, and heterosexist ideas and attitudes, I have worked hard to become more aware of the biases that I have internalized and eliminate them from my worldview. I realize that this is an ongoing process, and I likely still have a number of blind spots in these areas. I also know that I have not had the lived experience of being a person of color; a woman; a lesbian, gay, bisexual or transgendered individual; a non-Christian, or a person living in the lowest socioeconomic strata in this society. I do not pretend to portray myself as someone I am not. I do, however, endorse the social justice agenda and the values of the feminist and critical theory paradigms. I strive to be multiculturally competent and empowering in my clinical work and in my research activities.

Finally, as I have had personal experience in both the roles of client and therapist, I have a strong personal belief in the importance and power of the therapeutic relationship as a catalyst for positive change in psychotherapy. This value, perhaps more than any other, has influenced my interest in this research study. I am fully aware of my bias in

this area; and, although the purpose of this study is to examine others' experiences of this phenomenon, I have tried to take the phenomenological strategy of bracketing seriously and purposely used neutral language when asking about or discussing the therapeutic relationship with research participants. In this way I have tried to set my assumptions aside and honor their unique experiences.

In addition to being mindful of the values and biases mentioned above, there are a number of methods I employed to achieve and maintain reflexivity throughout this study. I kept a self-reflective journal throughout the data gathering and analysis processes, in which I tried to record and bracket the personal thoughts and feelings that came up regarding the study (Morrow, 2005). I also used participant checks to engage the participants as active co-creators of meaning and to ensure that my interpretation of their reality was represented accurately (Morrow, 2005). Finally, I consulted regularly with my research team as well as my advisor. I discussed my reactions, requested feedback in pointing out relevant issues and potential biases, and asked them to challenge my interpretations by suggesting alternatives. I also regularly examined my attitudes and assumptions regarding psychotherapy, the role of the therapeutic relationship, and the meaning of interpersonal differences with colleagues, fellow interns, therapy clients, and internship supervisors during the year-long data collection process. Using these approaches, I believe I was better able to enter the phenomenological experience of my participants to become an effective qualitative research instrument.

Although I attempted to bracket my personal opinions and beliefs and minimize the impact of my identities throughout my work on this study, it is clear that who I am as a person and a researcher affected this process. As a therapist I have a personal bias

regarding the value of psychotherapy. This bias is reflected in my decision to devote my life to a career in psychology, specifically focusing on clinical work. I consider psychotherapy to be a positive yet challenging process, with the potential to be a healing and empowering force in people's lives. I personally identify as an integrative therapist who draws from a number of traditions but maintains a strong existential-humanist core. I acknowledge that, as someone who works from a primarily existential-humanist conceptual framework, I have a clear bias towards the importance of the relationship in therapy and believe my clinical work reflects this stance. I also have a belief that therapists are impacted and often changed by the relationships formed with their clients.

Throughout the process of conducting interviews and analyzing the data, it was important for me to be mindful of my biases and not allow them to get in the way of understanding my participants' unique points of view. I was aware that some of my biases regarding the nature of therapy and multiculturalism, as well as my personal sociopolitical worldview, could become barriers to truly hearing opposing perspectives. I tried to be especially sensitive when engaging client participants. I felt that these participants were taking a risk and granting me the privilege of entering into a meaningful relationship that held a special place in their personal world. Therefore I wanted to tread lightly and avoid communicating any judgment or invalidation of their experiences.

I felt a different pressure when interacting with therapist participants. As a student and an intern, I found myself at times feeling like an upstart; a novice questioning a master. I had great respect for each of the therapists in the study and admired their work. As I prepared for the therapist interviews, I realized that I idealized many of the therapists in my study. This brought up some anxiety and worries about appearing

stupid, inarticulate, or even offensive during the interviews. I even became concerned about what might happen if my idealized image of some of these therapists became tarnished due to something they expressed in the interview. In a way it felt as though I was pulling back a sacred curtain of sorts, and part of me was afraid of what I might find behind it.

As I became more aware of these concerns, I relied more on my self-reflective journal and consultations with peers on my research team, my adviser, other interns, and internship supervisors. I made a more concerted effort to bracket any personal reactions and process them outside of any interactions with research participants. Reflecting back, this was a critical part of the data collection.

My self-reflective journal was particularly important throughout the interview process. The journal was organized into three separate sections: Personal reactions/feelings, thoughts about data/information, field notes/observations during interviews. The first section contained my personal reactions to the interviews as well as to the general themes emerging in the data. I recorded thoughts about the data and potential themes that seemed to be taking shape during the collection process in the second section. The third section of the journal served as more traditional field notes where I recorded observations made during interviews such as participants' presentation, descriptions of the settings used for each interview, and anything else that seemed noteworthy. I attempted to record notes in my journal immediately after each interview, though this was not always possible due to time. Although I had planned to make detailed notes, most of the entries were simple lists, key words and incomplete sentences which served to cue my memory later. Throughout the interview process, my journal did

help to identify issues and concerns to bring up to my research group and adviser. It also helped to refer to the journal during the data analysis when I was conceptualizing the structure of the results and integrating client/therapist themes.

My peer research team was also quite helpful during all phases of the study. They helped identify benefits and risks of several issues that came up including the idea of recruiting current therapy clients, and using client identified critical events in therapy. The research team and other colleagues also provided potential avenues of recruiting participants and served as a sounding board during data analysis. A number of people, including research team members, my adviser, fellow interns, and intern supervisors also provided much needed support and encouragement throughout process, especially in regards to the difficulties encountered in finding participants and the increased amount of time taken up by data analysis and writing.

As I began to conduct interviews with clients and therapists, I realized that I had some clear expectations and assumptions regarding what I would find. I recorded these expectations in my journal as an attempt to bring them to the forefront of my awareness, bracket them, and reduce their influence on my perception of the data. It was helpful to refer back to these expectations at various times during the study. Some of the strongest expectations I recorded are listed below:

- The relationship will be important to clients and therapists, but perhaps more so to clients.
- Differences between client and therapist will be of primary importance and have serious impact on therapy relationship.

- Certain differences such as race/ethnicity, gender, and sexual orientation will have the greatest impact on the relationship.
- There will likely be noticeable variation in relationship satisfaction between pairs.
- The themes may be very complex as each relationship is unique.
- Themes may be simple due to common factors contributing to the relationship.
- It should be easy to recruit participants through therapists I know in the community, my internship site, and through APA listserves.
- Participants will easily discuss overt/visible differences, but nonvisible differences may be more difficult to address.
- I am comfortable discussing any client/therapist differences with participants.

Participants

Qualitative research does not seek to sample statistically representative groups in order to make inferences about a population of people. Instead, participants in qualitative research are purposefully selected based on their experience of the phenomenon under investigation. In this way, multiple perspectives may provide a deeper understanding of both the unique aspects and common core experiences associated with the phenomenon (Polkinghorne, 2005). The participants for this study were individuals actively engaged in a client-therapist psychotherapy dyad in which the therapist was a licensed psychologist and one or more cross-cultural differences were present. The criteria for cross-cultural differences were broadly defined as to include, but not limited to, race, ethnicity, gender, sexual orientation, socioeconomic status, and religion or spiritual belief. Although there were no demographic limits placed on individual participants per

se, for the purposes of this study, I sought to recruit for maximum variation and attempted to include participant dyads in which a variety of cross-cultural differences were present, from various treatment settings. Although there are no rules for sample size in qualitative research (Patton, 2002), my goal was to have a minimum of 12 psychotherapy dyads (12 clients and 12 therapists, for a total of 24 individuals) representing different types of cross-cultural therapy relationships participating in this study, with the maximum number to be determined by the iterative process of examining the data for redundancy and saturation of information and themes (Polkinghorne, 2005). It was determined that saturation of information was achieved after 13 psychotherapy dyads were interviewed.

Selection Procedures

All qualitative studies use purposeful selection in order to study the experience of information-rich cases or participants who have direct experience with the phenomenon under investigation (Patton, 2002; Polkinghorne, 2005). A number of additional selection strategies are used in qualitative research depending on the experiences being examined. For this study, I used both criterion selection, and maximum variation selection. Criterion selection refers to the limits placed on participants selected for the study (Patton, 2002). The criteria for participation in this study included current engagement in a cross-cultural therapeutic relationship dyad, in which the therapist is a licensed psychologist. Maximum variation selection involves seeking out participants who represent a wide variety of perspectives or experiences with the phenomenon of inquiry (Patton, 2002). I attempted to select participants for this study who represented a variety

of different types of cross-cultural relationships, as well as psychotherapy dyads from a variety of treatment settings, such as university counseling centers and private practice offices.

Additionally, snowball sampling was used in this study. This is a method of identifying key individuals who may provide information rich cases, by asking people with some knowledge of the phenomenon to provide names of others they would recommend as potential participants based on the study criteria (Patton, 2002). As new participants were identified, they, in turn, suggested additional contacts and sources of participant recruitment.

Recruitment

The recruitment procedures for this study underwent a number of changes throughout the year long recruitment process. These changes were the result of additional requirements from another university's IRB where I recruited participants, specific agency requirements, and the addition of a monetary compensation for the purpose of attracting more interest in the study. I initially recruited participants by first contacting licensed psychologists who were currently providing individual psychotherapy in university counseling centers, VA clinics, community mental health centers, and in private practice and provided them with a brief description of the study. I then asked them to identify any current therapy clients who may have met the study criteria and to provide these clients with a written description of the study including my contact information, which directed them to initiate contact with me if they wished to participate.

The clients were to contact me directly to become participants and find out more information regarding the study.

In this initial recruitment phase, several psychologists were contacted through existing connections with local mental health agencies, in accordance with relevant agency procedures, or directly for those in private practice. Recruitment flyers were also provided to local agencies to post in areas visible to clients and to current and former colleagues working in the field to post in their current work settings. In an effort to recruit participants beyond my local geographic area, an electronic flyer was sent to a broader group of psychologists via the Utah Psychological Association listserve, as well as the listserves for APA Division 17 Section for the Advancement of Women (SAW), APA Division 29 Psychotherapy, and APA Division 51 Study of Men and Masculinity explaining the study and providing contact information. A number of other APA divisions were contacted but did not express interest or failed to reply after numerous requests.

It was very important that, during the recruitment for this study, no clients felt pressure to participate in order to please their therapists. In an effort to avoid this and protect clients, therapists who expressed a willingness to participate were asked to provide the recruitment information to more than one client and to tell clients that this is what they were doing. In this way, clients were less likely to feel like they would be disappointing their therapists if they decided not to participate. This was also to "mask" the identity of clients who decided not to participate. Therapists were informed that, as clients contacted me to express interest; I would choose only one of their clients or none at all, depending on the overall response rate and need for diversity among participants.

Client participants were also informed that, unless they informed their therapist, the therapist would not actually know if they attempted to contact me. The therapist would only have had knowledge of any contact if their client/therapist dyad was selected to participate in the study. In this way, clients were assured that if they did not want to participate, their therapists would not know unless they told them. Additionally, interested clients who learned of the study through advertisements or word of mouth could approach their therapists and contact me directly to become involved. Six participant dyads were recruited under these initial procedures.

In order to expand recruitment, an IRB request was submitted to Brigham Young University (BYU) for the purpose of recruiting participants through the BYU Counseling and Career Center. In addition, an amendment to the original University of Utah IRB proposal was submitted to add compensation in the form of a $10 gift card for client participants. The amendment to provide compensation was approved and the BYU IRB approved the study request with a few critical changes to the recruitment procedures.

In accordance with the BYU IRB, the recruitment procedures were changed to primarily recruit through psychotherapy clients in order to further avoid any problems with coercion. Under the new recruitment procedures, recruitment flyers containing a brief explanation of the study and inclusion criteria were provided to clients from office reception staff at counseling centers and private practice locations. The flyers instructed clients to provide contact information on the back side and bring the flyer to their psychologists if they wished to take part in the study. The psychologists then, if they also chose to take part in the study, completed the back side of the flyer with their own contact information and stored the flyer in a secure place for me to pick up. One additional

change required by the BYU IRB involved creating a Demographic Questionnaire containing printed versions of the demographic questions originally asked at the start of the participant interviews. Participants were asked to complete this questionnaire just before the start of the interview. The rationale provided for this change was to minimize any potential discomfort that could be experienced by participants if asked to respond to demographic questions verbally. Two participant dyads were recruited under these procedures.

As a result of continued low participant numbers, IRB amendments requesting an increase in the compensation for client participants from $10 to $25 were submitted and approved by the University of Utah and BYU IRBs. Two additional participant dyads were recruited following this amendment approval.

Finally, in an effort to expand the recruitment locations and obtain more diversity in the participant dyads, the University Counseling Center (UCC) at the University of Utah was approached to recruit participants. The UCC Research Committee reviewed the study information and requested some further changes in recruitment procedures. These changes were agreed upon and then approved as an amendment to the original University of Utah IRB study. The changes consisted of listing the names of licensed UCC psychologists who agreed to participate on the recruitment flyer and eliminating the step involving clients approaching their therapists about participation. These changes were made so clients would know prior to deciding whether or not to get involved, if their therapist was eligible and willing to participate. These changes also further minimized the risk of client coercion. Three participant dyads were recruited under these procedures.

It should be noted that, despite having been informed of the detailed recruitment procedures outlined above, some therapists reported that they ignored these procedures. A few disclosed that they recruited clients directly and/or approached only one client they thought would be a "good participant" for this study. This information was typically revealed after the interviews. No participants were excluded due to violations of recruitment procedures.

Participant Demographics

In an effort to achieve maximum variation and provide an opportunity for the voices of members of minority and historically marginalized groups to be heard, I sought to recruit study participants representing a range of different backgrounds and identities as well as a range of differences in their therapy dyads. Each participant provided some basic demographic information either verbally, under the original recruitment procedures, or in the form of a written Demographic Questionnaire regarding their gender, age, race/ethnicity, sexual orientation, relationship status, and religious affiliation. In addition, therapists were asked to briefly describe their therapeutic orientations.

A number of identified differences were represented among the 13 therapy pairs involved in this study. These differences included race/ethnicity, gender/gender identity, religious affiliation, age and experience, SES, sexual orientation, relationship status/relationship orientation, life experience and trauma, personality style, appearance, and language. These differences in therapy pairs are illustrated in Table 1.

Table 1: Cross-Cultural Differences Identified in Participant Relationships

Type of Difference	**Number of Pairs**
Gender/Gender Identity	6
Race/Ethnicity/Culture	7
Age and Experience	11
Religious Affiliation	7
Sexual Orientation	3
SES	6
Relationship Status/ Relationship Orientation	6
Personality Style	4
Life Experience and Trauma	6
Appearance	2
Language	1

Race/Ethnicity

Nineteen of the participants in this study identified as White/Caucasian or European American, including eight of the client participants and eleven of the therapist participants. Three participants, two clients and one therapist, identified as Latino(a), Hispanic, or Chicano. Two of these participants further identified themselves as being specifically Mexican American and one identified as Venezuelan. One participant in the study identified as Japanese American. One participant identified as Asian. Three participants identified themselves as multiracial. These participants further described

their racial/ethnic background as Samoan/Filipino, Hispanic/Caucasian/American Indian, and Caucasian with some Native American.

Age

The ages of participants ranged considerably from 22 to 61, with an overall mean participant age of 40. Clients were generally younger than therapists. Clients ranged in age from 22 to 59, with a mean age of 34. Therapists' ages ranged from 35 to 61, with a mean of 46. In terms of cohorts, six participants (all clients) were between the ages of 22 and 30, seven participants (three clients and four therapists) were between the ages of 31 and 40, five participants (three clients and two therapists) were between the ages of 41 and 50, seven participants (one client and six therapists) were between the ages of 51 and 60, and one participant (therapist) was over age 60. The difference in age between clients and therapists within therapy pairs ranged from 2 years to 37 years, with a mean age difference of 16 years. In all but 2 of the 13 pairs, therapists were older than clients.

Gender

Ten participants in this study identified as women. This included three clients and seven therapists. Fifteen participants identified as men, including nine clients and six therapists. One client participant in this study identified as transgendered.

Sexual Orientation

Twenty three participants in this study identified their sexual orientation as heterosexual, straight, or "attracted to the opposite sex." This included all thirteen of the

therapists and ten of the clients. Two client participants identified their sexual orientation as gay. One client identified as queer.

Religious Affiliation

Twelve participants identified their religious affiliation as being members of the Church of Jesus Christ of Latter-day Saints (LDS, or Mormon). This included seven clients and five therapists in the study. Two of these client participants who self-identified as Mormon elaborated further on their religious affiliation. One was more specific in describing himself as an inactive/nonpracticing member of the LDS church, and another endorsed having "disagreements" and "questions about the [Mormon] theology" on the Demographic Questionnaire. Two client participants identified themselves as being Roman Catholic, with one of these describing himself as "nonpracticing." Two clients identified themselves as endorsing a Christian belief system, with one describing his religious/spiritual affiliation as "Christian-ish," and another identifying as having been raised in the Catholic tradition, but wrote, "I do not believe in the church. I do believe in God, Jesus Christ, and the Holy Ghost." Two therapist participants described themselves as being spiritual but not affiliated with a particular organized religion, with one identifying as being "most inclined to Buddhist philosophies." One therapist identified as "historically LDS" but currently not active/nonpracticing. Another therapist described himself as agnostic, but "draw[ing] strength from Buddhist framework/worldview." Seven participants reported having no specific religious affiliation.

Professional Experience and Theoretical Orientation

There was considerable range in terms of professional experience and theoretical orientations of therapists who participated in this study. Therapists reported a range of experience in professional postdoctoral practice from approximately 2 to over 30 years. All therapists reported receiving graduate training in either Counseling Psychology or Clinical Psychology doctoral programs.

Along with the basic demographic information, therapists in this study were asked to briefly describe their theoretical orientation to psychotherapy. Most therapists described themselves as being eclectic, integrative, or being influenced by a number of different theories or approaches to therapy. Four of the thirteen therapists identified as primarily drawing on a single school of therapy. Two of the four identified as Cognitive-Behavioral psychologists, one identified as a "devout" practitioner of Rational-Emotive Behavior Therapy (REBT), and one therapist identified as Constructivist. Three therapists first mentioned Existential or Humanistic-Existential when describing their orientation, while also endorsing integration of other theories as well. One of these therapists also identified as Interpersonal and integrating elements of CBT, Dialectical Behavior Therapy (DBT), Feminist therapy and positive psychology. The second endorsed a "very client-centered approach," stressing choice, meaning and "meeting people where they are at." The third Existential integrative therapist also mentioned Interpersonal Process, Feminist/Feminist-Multicultural, and CBT as theories draw upon in clinical work. One therapist reported using an Acceptance and Commitment Therapy (ACT) approach while also using past training in Child-Centered Play Therapy and CBT. One therapist identified as coming from a family systems approach and utilizing CBT

and Gestalt techniques. Another therapist described her orientation to therapy as "Multicultural, but not Feminist," and Humanistic-Existential. One reported integrating Humanistic, Interpersonal Process, emotion-based, and mindfulness approaches. Finally, one therapist described himself as Integrative with "special emphasis on mindfulness-based approaches."

Relationship Status

Seventeen study participants identified themselves as being married, partnered, or in a committed relationship. This included eight clients and nine therapists. Five participants, including two clients and three therapists, identified as being divorced or separated. Six participants, five clients and one therapist, identified themselves as being single, dating, or not in a committed relationship at the time of their interview.

Geographical and Practice Setting

All participants in this study were recruited from the Intermountain West region of the US. Twelve of the therapy dyads were recruited from urban areas, including one from a large city, six from a medium sized city, five from a small city, and one dyad from a small town in a rural area.

Therapy pairs in this study were recruited from a variety of practice settings. Seven of the therapy pairs were recruited from university counseling centers. Three of these pairs came from a large public university and four pairs came from a large private, religiously affiliated university. The other six therapy pairs were recruited from private practice settings.

Interview Setting

Morrow and Smith (2000) stated that the physical environment of participant interviews in qualitative research can have important implications regarding the rigor and trustworthiness of a study. The physical setting of an interview can influence participants' verbal and behavioral responses (Patton, 2002). For these reasons, careful thought was given to the setting for each interview, and participants were given the final choice of interview locations. Participants were informed that the most important factors in selecting a location for our interviews were their personal comfort, convenience, privacy, and an appropriately low level of noise/distractions. All but one of the participant interviews were conducted in person. Due to geographic distance, one therapist interview was conducted by phone from my intern office at a mutually agreed upon time. Ten interviews, nine therapists and one client, were conducted in the therapists' offices. The one client interviewed in his therapist's office chose this location for comfort and convenience. Seven of the interviews, two therapists and five clients, were done in the interviewees' homes. Four interviews, one therapist and three clients, took place in my intern office. Two clients chose to be interviewed in a separate office located at their therapist's agency. Finally, one client chose to be interviewed in a private room at his workplace, and one client chose to have the interview take place at an agreed upon location on the campus of his university. In each location, I attempted to minimize any distractions and ensure privacy to maintain confidentiality.

Researcher Roles and Relationship with Participants

As the researcher for this study, I recruited participants and gathered and analyzed all data. I gathered data in the form of individual interviews with clients and therapists and engaged them in participant checks of my interpretation of the data. In this way, the participants in this study also served as co-researchers. Engaging the participants as co-researchers was a way of ensuring accurate representation of their experiences and reflection of meaning related to the phenomenon studied (Morrow, 2005). Participant checks can provide participants with the opportunity to give feedback and make corrections as necessary during the data analysis process and to achieve a level of fairness in the research study (Morrow, 2005). This inclusion of participants as co-researchers is consistent with both the social constructionist and critical theory paradigms and allowed the participants a clear voice in the research process.

Taking Leave

Qualitative research methodologies are uniquely positioned to illuminate the lived experiences of participants and provide deeper understanding of the meanings they construct around particular phenomena. As such, engaging in qualitative research can be an emotional, even life-changing experience for both researcher and participant. Given the level of intimacy in this relationship, it is important for the researcher to take leave in a respectful manner. In addition to providing my participants with a thorough informed consent prior to conducting their interviews, I invited participants to engage in follow-up interviews and participant checks in order to clarify information and process any feelings regarding their involvement in the research process. I also expressed my gratitude to the

participants for their involvement and attempted to honor their willingness to share their personal experiences. Finally, I informed participants that they were welcome to contact me with additional information as needed following our interviews. I also provided them with information regarding additional counseling and crisis resources to use as needed.

Sources of Data

Rather than attempting to prove the validity of a single truth, as in quantitative methodologies, qualitative research uses multiple sources of data to gain a better understanding of the multiple realities of participants (Denzin & Lincoln, 2005). Including different sources and types of data in qualitative research is important to achieve triangulation, or the ability to examine the phenomenon of inquiry from more than one perspective (Patton, 2002). Richardson and St. Pierre (2005) preferred to conceptualize this process as crystallization, wherein the depth and complexity of the phenomenon is seen as light refracted through many different facets of a crystal. Morrow (2005) recommended the use of multiple data sources in order to obtain sufficient variety of data as well as strengthen the interpretive status of the data. For this study, I used individual interviews and participant checks, to better understand the lived experience of the cross-cultural therapeutic relationship.

Interviews

Interviews are an important method of inquiry into participants' various experiences of complex phenomena (Patton, 2002; Wertz, 2005). Seidman (1998) asserted that the purpose of phenomenological interviews is not to gain answers to

specific questions, but rather to gain understanding of the experience, context, and meaning making processes of others. Participants in this study were asked to engage in one 60 to 90 minute individual interview to explore their experience in cross-cultural therapeutic relationships.

It has been recommended to establish a warm, safe, and respectful environment for qualitative interviews, in which the participants feel comfortable sharing their experiences (Kvale, 1996). For this study, I used a semistructured interview guide approach as outlined by Patton (2002), employing a set of predetermined open-ended questions as well as prompts for additional information (see Interview Questions below). As the nature of qualitative research is emergent, the interview guide served as a general structure which was adapted and shaped based on information and themes that arose in the individual interviews (Morrow & Smith, 2000).

Each interview began with informal greetings and an explanation of the purpose of the interview as well as a discussion regarding the informed consent prior to asking participants to sign it. Interviews consisted of open-ended questions, starting with a very general question about the participants' experiences of their therapeutic relationship, and becoming progressively more focused on their perceptions of differences in the relationship and how those differences have impacted the relationship. Participants were allowed to elaborate on different themes as they saw fit. As the interviewer, I also pursued relevant themes as they emerged. Although the interviews were originally planned to last between 60-90 minutes, the actual interview length ranged from 35 to 120 minutes. A digital video recorder was used to record all interviews, with each participant's consent, to ensure accuracy of data collection.

Two questions were added to the interview guide after the first six interviews. These questions were *What do you think has been most helpful for you/your client in your work together?* and *How important do you think it is to like the clients you work with?* These two questions represented themes that participants brought up consistently in the first three client/therapist pairs. As I became aware of these themes and reflected on the meaning they had for participants, I decided that they were an important part of participants' experience of the therapeutic relationship and added them to the interview guide. After the first three interview pairs, each subsequent participant was asked the first question and each therapist was asked the second. A number of the remaining participants, however, brought the themes up before being asked.

Interview Questions

The following list of interview questions was used to guide the interviews:

1. Tell me about the relationship between you and your client/therapist.

2a. What was it like for you to seek out a therapist and get started in therapy? (Clients only)

    a. How did you choose your therapist?

2b. How was your client referred to you? (Therapists only)

3. What has contributed to or strengthened your relationship?

    a. Can you give me a specific example?

4. What challenges or barriers have you experienced in your relationship?

    a. Have you experienced any conflicts in your relationship?

    b. Can you give me a specific example?

5. In what important ways do you see yourself and your and client/therapist as different from each other?

    a. Are there any other differences you perceive or experience between yourself and client/therapist?

6. Describe how these differences impact your thoughts and feelings about yourself/your identity.

    a. In what ways do these different aspects of your identity contribute to who you are?

7. How have these differences impacted your relationship with your client/ therapist?

    a. Can you give me a specific example?

8. How have these differences been addressed in your relationship?

9. Thinking about your relationship with your client/therapist, is there anything we haven't talked about that you think is important?

10. What do you think has been most helpful for you/your client in your work together? *

11. How important do you think it is to like the clients you work with? (therapists only) *

12. Tell me what it has been like for you to talk to me about your relationship with your client/therapist?

    a. What has this experience been like for you?

* Questions added based on initial interview data.

Participant Experience of Interviews

As listed above, the last interview question asked of each participant inquired about their experience of being interviewed. A number of themes emerged from

participant responses to this question. Seven of the thirteen client participants talked about feeling "safe" or "comfortable" speaking with me, and a few likened it to their therapy experience. Five clients mentioned feeling appreciative of the opportunity to reflect on their relationship with their therapists and the positive work they have done in therapy. Three clients focused on their motivation for getting involved in the study. They commented on their willingness to help me progress and complete my degree (though we had not met prior to their involvement in the study); their interest in the subject matter; and their genuine affection for their therapists, including a desire to acknowledge the meaningful impact their therapists had had on their lives.

Therapists had somewhat similar reactions. Eight therapists focused on the experience of discussing their relationships and the work they had done with their clients. These therapists expressed appreciation for the opportunity to reflect on their work. Some remarked that they do not typically have any other forum in which to discuss their clients. They also commented on the value of being forced to look at their client relationships from a different perspective. A few of these therapists also mentioned having positive or "warm" feelings toward their clients as they reflected on the relationship during the interview. Two therapists discussed their comfort level with me throughout the interview. One reported feeling anxious during the beginning part of the interview about "not knowing what you were going to ask." This therapist mentioned some concern over confidentiality, but stated her worries resolved as the interview progressed. The other therapist commented on feeling "safe" with me due to having some familiarity with my training program and the knowledge that I had done my own "work" around issues of White privilege. Finally, one therapist talked about his

motivation for getting involved in the study. He expressed a great interest in multicultural issues and an appreciation for this research. This therapist also stated that he had a desire to support me and help me complete my degree.

Participant Observations

Participant observations are often used in qualitative studies to help supplement and clarify information obtained in interviews (Polkinghorne, 2005). The option to be involved in a participant observation, in the form of a video recording of a single therapy session, was presented to each dyad as a voluntary part of the study. Each dyad was given the opportunity to have a therapy session recorded by the researcher for data analysis and review in individual follow-up interviews. The video recording was to take place prior to individual interviews, in order to observe the client/therapist relationship prior to introducing any influence based on the interview questions. The video recorded sessions were then to be reviewed by the researcher after individual interviews with each client/therapist dyad. None of the client/therapy dyads agreed to take part in participant observations for this study.

Follow-up Interviews

Each participant was asked respond to a series of brief follow-up questions based on information discussed in their initial interview and emergent themes from the data analysis. These follow-up interviews took place via e-mail after the initial data were reviewed and analyzed. I wanted to provide participants with an opportunity to express themselves and describe their experiences in a setting of their choosing without me. As I

reflected on my experiences of the interviews and the themes that emerged, it seemed likely that my presence, as a heterosexual, White, male graduate student may have impacted some participant responses. In addition, I was concerned that other characteristics and roles I had in relation to some participants such as Psychology Intern, former trainee, and colleague, may also have influenced interview responses. Providing participants with the option of responding to follow-up questions in a manner that created some distance between us seemed important. It also allowed participants a chance to respond using a different modality, which added another type of source to the data collection process. No individually identifying information, such as client or therapists names, was used in the follow-up e-mails. Participants were given the option of responding by replying to my e-mail or speaking to me directly over the phone. All those who responded chose to reply by e-mail. The following list of questions was used for the follow-up e-mail interviews:

1. Are there any things you feel are not accurate/misrepresentative based on your experience?

2. Are there any quotes you feel are too identifying (too easily attributed to you)?

3. Do you have any overall feedback about the themes mentioned in the Results? Is there anything you think may be important to add based on your experience?

4. Since our interview, have you talked about the interview experience with your client/therapist? If so, what happened (Please do not use names)?

*5. Some people may be more comfortable and open talking to someone more like them, for example, someone of the same age, gender, race, sexual orientation, religion, etc. Did

any of the differences between you and me impact what you talked about in our interview together?

* Sent to clients only

Participant Checks

The use of participant checks in qualitative research is an essential strategy in achieving triangulation (Morrow, 2005) and providing research participants with a way of checking the integrity and fidelity of the researcher's interpretation of their stories (Creswell, 1998). I originally intended to invite each participant to take part in one optional 30 to 60 minute participant check following preliminary analysis of the data. Participants were to be given the option of engaging in in-person participant checks individually or in small focus groups of clients or therapists. They were also to be given the option of engaging in the participant check over the phone or via e-mail for convenience. However, once the initial data analysis was complete, it became apparent that inviting participants to attend focus groups would involve a sacrifice of confidentiality. A number of therapist participants were either co-workers in the same agency or knew one another in some way, and holding a focus group for therapists would eliminate their opportunity to maintain confidentiality. Additionally, planning several focus groups in which therapists from the same agency or with known affiliations were not invited to the same group became too complicated and time-consuming.

The purpose of the participant checks was to allow for further clarification of meanings and themes and ensure that my interpretation of the participants' experience was accurate. It was also an attempt to provide the participants with a more active,

empowered role in the research process and allow their voices to be heard in the final product, which is consistent with feminist research values (Charmaz, 2005). Providing this opportunity for participants to play an active role in the research was still very important to me, therefore I consulted my research group and my adviser and came up with an alternative participant check procedure which combined the participant check and follow-up interview.

The participant checks were conducted in the following manner. A preliminary version of the analyzed study results section was sent to each participant along with the follow-up interview questions. All interview data sent to participants via e-mail were deidentified, and no personal information directly associating the participant to the study data was included. These versions were edited according to role in the therapy relationship. Client participants were sent a client version that contained quotes only from clients and in which all therapist quotes were removed. Therapist participants were sent a therapist version of the results that contained only therapist quotes and in which all client quotes were removed. The purpose of sending these edited versions was twofold. The first goal of the participant checks was to have each participant review the quotes attributed to her/him for accuracy and allow them an opportunity to clarify or express any concerns about confidentiality. Due to the nature of this study, it became clear that certain quotes included in the results could likely be attributed to specific participants by their therapy partners. In other words, due to the shared relationships between clients and therapists, a client could have reasonably recognized some quotes as coming from her or his therapist, despite the fact that the therapist was given a pseudonym, thereby threatening the therapist's confidentiality. The same was true for therapists recognizing

clients through identifiable quotes. Participants were directed to express any concerns regarding identifiable quotes to me and that we would collaborate to resolve the problem in a way that would alleviate their concerns and maintain the integrity of the data. Participants were also informed that, ultimately, their right to confidentiality would be placed ahead of all other issues regarding data.

The second reason for sending edited client and therapist versions of the results section was to maintain the integrity of each group's descriptions of their phenomenological experience. I wanted to prevent one group of participants' responses from being influenced by reading what the other group had to say. I did not want clients to change their perceptions of the therapy relationship to fit therapists' descriptions or therapists to change their responses based on clients' perceptions of the relationship.

Twelve of the original 26 participants responded to the participant check. The remaining fourteen participants did not respond after multiple attempts to contact them and solicit feedback. Eleven of those participants who responded answered all of the follow-up questions. Two participants who responded pointed out some corrections or clarifications. These were primarily minor grammatical corrections and changes to demographic descriptors. I revised the information in the Results section to reflect the corrections/clarifications they provided. None of these changes had any substantial impact on the themes or major findings of the study. One of the participants who responded to the participant check indicated some concern about identifiable information in one of her quotes. Out of respect for her right to confidentiality, I deleted the identifiable information. The rest of her quote was retained as this deletion did not

change the meaning or context of the quote. Each participant who responded also indicated that the study findings accurately represented their experiences.

Of the twelve participants who responded to the follow-up participant check, three therapists and one client indicated they had a conversation about the interviews with their therapy partner. One of these therapists reported, "While we didn't share much of our respective interviews at a content level, we did focus for a few minutes on the process of it—that we both had enjoyed reflecting on the relationship and talking to a third party about it." The others simply stated that they acknowledged the interviews had taken place with their therapy partner or commented on the experience being "interesting."

In response to the potential impact of differences in our interview dyad, one client participant indicated that he felt somewhat "nervous" at first and engaged in some "testing" behavior around differences, but then felt comfortable as the interview progressed. No other client participants who responded noted any impact or concern related to differences or my identities.

Data Analysis

Data Management

The data corpus of this study consisted of video-recorded individual interview data, written participant check feedback, and my field notes taken before and after interviews. Each interview was transcribed by one of three different professional transcriptionists. Each transcriptionist signed a confidentiality statement in which they agreed not to disclose any of the study data and delete all interview material upon

completion. The audio recording was extracted from each interview video and sent to the transcriptionists via an encrypted, password-protected e-mail attachment. Each completed interview transcription was then sent to me via an encrypted, password-protected e-mail attachment. In an effort to gain a greater sense of mastery of the interview content, as well as fully immerse myself in the words and experience of the participants, I watched each interview video recording multiple times and compared the recording to each transcription to ensure accuracy. All interview recordings, transcripts, and field notes were kept in a locked file cabinet in my home and in digital form on my laptop computer, which is password protected, to ensure safety and confidentiality (Patton, 2002).

Data Analysis

Phenomenological qualitative research is an inductive process; and, as such, themes and patterns must be allowed to emerge from the data throughout the analysis (Patton, 2002; Wertz, 2005). This emergent stance is also consistent with constructionist and critical theory paradigms, which place primary emphasis on the voices of participants and their interpretations of meaning. Additionally, as is appropriate in a phenomenological design, I bracketed my personal thoughts and feelings in a self-reflective journal as I began to conduct interviews and analyze data.

The following data analysis procedures were based the phenomenological methods outlined by Giorgi (2009) and Wertz (2005). The steps I used for data analysis were: 1) Read for the sense of the whole; 2) Identify meaning units; 3) Reflect and interpret meaning units; and 4) Describe structure of the phenomenological experience.

An essential part of the data analysis process in qualitative research is immersion in the data (Morrow, 2005; Patton, 2002). Once the interviews were transcribed, I viewed each interview several times while reading through the transcripts to check the accuracy of the transcription and develop a good holistic sense of the data. This allowed me to get a better understanding of the tone and texture of each interview while being mindful of clues alluding to the lifeworld of the participant (Giorgi, 2009). Next, I identified meaning units throughout the transcripts by highlighting significant passages, cutting and pasting portions of the interview text, and using notes to flag key sections. Each distinct meaning unit was cut out and glued to a large index card. Over 1000 meaning units were initially identified in the 26 participant interviews. I then organized meaning units identified in the previous step into emergent themes for both clients and therapists, keeping each group separate. At this point, I also actively searched for disconfirming evidence as themes emerge from the data.

Once the emerging structure of the phenomenon began to take shape, I organized the themes for clients and therapists into separate subthemes and higher level or main themes. At this point in the process, I decided to review my field notes and the interview transcripts once again. After doing this and reflecting further on the emergent structure of the data, I went back over each meaning unit a second time and reorganized them into a new theme structure, combining some subthemes and realigning others under new higher level themes for both clients and therapists. It was at this point that I began to compare and integrate the themes from client interviews and the themes from therapist interviews. An overall structure emerged from integrating both sets of interview themes with significant overlapping of themes as well as some themes that remained unique to

each group. I presented the structure to participants individually to obtain feedback regarding the accuracy of my description and engage them in the research process. Throughout this process, I also consulted with my advisor, peer research group, and my self-reflective journal, in order to evaluate the impact of my own biases in the analysis and to insure that the bracketing process was carefully attended to. Finally, in the last stage of data analysis, I analyzed individual themes and experiences and synthesized them into a general structure of the phenomenon.

The finished product is a detailed description of the lived experience of the cross-cultural therapeutic relationship. This description contains numerous participant quotes used to illustrate and clarify the convergent and divergent themes that emerged in my analysis. The contribution of knowledge this study represents to the fields of counseling psychology and multicultural counseling is also discussed. Further, the impact that participation in this study had on the individual participants and their ongoing therapeutic relationships is described.

Ethical Considerations

Ethical considerations are essential to any research study. Throughout each aspect of this study, I closely adhered to the APA Ethic Principles and Code of Conduct (2002). Additionally, I obtained approval of the Institutional Review Boards of the University of Utah and Brigham Young University. Ongoing IRB approval was also obtained via amendments to the original proposal as the study procedures changed and evolved. Specific further ethical considerations involved in this study were handled in the following manner. Each participant was given a pseudonym to further protect

confidentiality. Prior to each interview, participants were briefed on the purpose and objectives of this study. The informed consent was also thoroughly reviewed with each participant, including any potential harm that could result in their participation, including strong emotional reactions evoked by interview themes or questions. Participants were be debriefed and screened for any distress following each interview and offered appropriate referral information to use as needed. No participants reported experiencing any distress as a result of the interviews. In addition, each participant was informed about confidentiality issues at the start of each interview. This included the limits to confidentiality as well as the steps I took to maintain security of participant interview recordings, session videos, and personal identifying information.

Once the results were written, a unique issue arose around confidentiality. It became apparent that certain participant quotes could potentially serve to identify individuals to their clients/therapists. This identifying content included descriptions of themselves or their therapy partners, autobiographical information, and information shared about themes discussed in their therapy sessions. I became concerned about this potential breach of confidentiality, but also valued the contribution the identifying quotes made to the overall study. In an effort to resolve this conflict, I decided to consult with and empower the study participants as a part of the participant check procedures. An edited version of the results section was sent to each participant based on their status as client or therapist. Clients were sent a version with all therapist quotes removed, and therapists were sent a version with client quotes deleted. Each individual participant's pseudonym was highlighted throughout the text in the version she/he received so as to be easily located. Participants were then directed to inform me if they found any quotes

attributed to them that were incorrect or problematic in terms of confidentiality. We then worked together to resolve any problems in such a way as to maintain the integrity of the study and achieve participants' desired level of confidentiality.

CHAPTER 3

RESULTS

The purpose of this study was to explore the experiences of clients and therapists in cross-cultural therapy relationships where one or more meaningful difference exists. After analyzing all interview data, a number of major themes and subthemes emerged. These themes are presented in two main parts, Part I *Experience of the Relationship* and Part II *Experience of Differences,* based on the two primary research questions. It should be noted that these parts are not mutually exclusive. The results are presented in two parts in order to highlight the experience of specific differences in the therapy relationship. There is considerable interaction and overlap between participants' experiences of the therapy relationship and their experiences of differences in the therapy relationship.

During their interviews, a few clients provided longer, more detailed examples of specific incidents they felt held great meaning for them. They described these critical events as the most emotionally powerful experiences in their therapeutic relationships. In each case, the client volunteered the description as a way to illustrate the deep personal feelings felt toward his/her therapist. These critical events are used to illustrate certain themes throughout the chapter.

Under *Experience of the Relationship*, the data yielded four major subthemes: *Referral and Initial Impressions, Development of Therapeutic Relationship, Shared Investment,* and *Emotional Connection*. These four themes are presented in the same order that most of the participants related the narrative of their therapy relationship, beginning with the referral and following the development of the relationship into a meaningful emotional connection. Each theme is discussed from the perspectives of both therapists and clients. Under the first major theme, *Referral and Initial Impressions*, three subthemes emerged *Referral Process*, *Previous Encounters and Therapy History*, and *Initial Impressions*. Exploration of the second major theme, *Development of Therapeutic Relationship,* yielded four subthemes: *Building Trust, Understanding Worldview*, *Balance of Power,* and *Positive Change*. Under the third major theme, *Shared Investment,* two subthemes emerged: *Therapist Investment in the Process* and *Client Investment in the Process*. Analysis of the fourth major theme under *Experience of Relationship, Emotional Connection*, yielded three subthemes: *Caring Relationships*, *Positive Perspective*, and *Liking Who I Work With*.

The second part of the results is *Experience of Differences*. Under this part, four main themes emerged: *Dimensions of Identity, Differences as Enhancing the Relationship, Building on Common Ground*, and *Power and Responsibility*. Analysis of *Dimensions of Identity* yielded 11 subthemes: *Race and Ethnicity*, *Gender and Gender Identity*, *Religion, Age and Experience, Relationship Status and Relationship Orientation*, *Socioeconomic Status*, *Sexual Orientation, Life Experiences and Trauma*, *Personality Style, Appearance*, and *Language*. Under each of these 11 subthemes, three additional subthemes are discussed: *Awareness of the Difference, Impact on Personal Identity*, and

Impact on Relationship. The themes and subthemes that emerged from this analysis are summarized in Table 2.

Part I - Experience of Relationship

All of the clients and therapists reported an overall positive or successful experience in therapy. While some acknowledged challenges or frustrating incidents that occurred over the course of therapy, no participants indicated their overall therapy experience was unhelpful or harmful in any way. This was no surprise, as I expected that only people involved in a satisfying therapy relationship would likely be interested in participating in this study. When speaking about their general impression of the relationship, therapists tended to provide an evaluative description that often included their perception of the client's experience, whereas clients tended to focus on their level of satisfaction with the relationship and their personal feelings toward the therapist.

As they shared their experiences of the therapeutic relationship, several clients, as well as a few therapists, described specific critical events that occurred in therapy. These critical events were incidents that held great meaning for the people involved and were often discussed in detail. They were typically used to illustrate intense emotional experiences or broader themes. Some of these critical events are presented below in order to accurately convey the participants' lived experience of the relationship.

All 13 therapists in the study described the relationship between their clients and themselves in generally positive terms. Each one indicated that she/he believed the relationship was a good one. These included descriptions such as this one by Barry, "I think it's a pretty good relationship," and another, by Arthur, "I feel we have a very

Table 2: Outline of Results

- *Part I-Experience of the Relationship*
  - *Theme 1-Referral and Initial Impressions*
    - *Referral Process*
    - *Previous Encounters and Therapy History*
    - *Initial Impressions*
  - *Theme 2-Development of Therapeutic Relationship*
    - *Building Trust*
      - *Establishing Trust*
      - *Validation*
      - *Consistency*
      - *Respect*
      - *Genuineness and Authenticity*
      - *Challenging in a Positive Way*
      - *Acceptance and Nonjudgment*
      - *Listening and Feeling Heard*
      - *Use of Humor*
    - *Understanding Worldview*
    - *Balance of Power*
    - *Positive Change*
  - *Theme 3-Shared Investment*
    - *Therapist Investment in the Process*
    - *Client Investment in the Process*
  - *Theme 4-Emotional Connection*
    - *Caring Relationships*
    - *Positive Perspective*
    - *Liking Who I Work With*
- *Part II-Experience of Differences*
  - *Theme 1-Dimensions of Identity*
    - Race, Ethnicity, and Culture
    - Gender and Gender Identity
    - Religion
    - Age and Experience
    - Socioeconomic Status
    - Sexual Orientation
    - Relationship Status and Relationship Orientation
    - Life Experience and Trauma
    - Personality Style
    - Appearance
    - Language
  - *Theme 2-Differences as Enhancing the Relationship*
  - *Theme 3-Building on Common Ground*
  - *Theme 4-Power and Responsibility*

strong relationship." Some therapists, such as Bruce, referred to objective measures they used to measure client satisfaction, on which the client indicated that she/he was pleased with the relationship and felt close to the therapist.

A few therapists were quick to further qualify the relationship, noting possible discrepancies between their perceptions and those of their clients, or addressing their adherence to professional boundaries. This may have been due to concern about appearing professional, or perhaps that their clients would present a differing view of the relationship. While these therapists admitted that their perceptions seemed positive, some acknowledged a degree of uncertainty. Barbara stated, "I really like him, I care about him, I expect he's perceived me as being reasonably supportive, but he's not one that I can really read as easily to know how he's feeling . . . It's harder for me to get a sense of how he feels about me." Oliver related, "I think it's pretty positive. I don't know that he sees it as being a warm, friendly relationship." Another therapist, Barry, after describing what seemed to be a very positive relationship, simply noted the client's continued attendance as evidence that "he gets some value from our meetings."

Some therapists commented on their awareness that clients may perceive the relationship in a less professional way; as more of a friendship rather than a psychotherapy relationship. Helena stated, "I think she would probably say that it has shifted into a friendship . . . I would think that would be the way she would describe it." When asked about the relationship with his client, Bruce explained:

> It depends on if you're talking to me or him, or my perception of him, because sometimes I think he sees me as a friend. And he really wants me to be a friend. And so, I touch on the friendship a little bit, but I'm still the professional and I have something to offer him - I believe. . . . But I think that's where it lies, is balancing his perception of wanting a friend, and my desire and sense of obligation to be a therapist for him.

Still others seemed to purposely make note of the clinical nature of the relationship, highlighting their awareness of professional boundaries at the outset of the interview. Selina stated, "I think we have a really good clinical relationship." And Kara simply said, "It's definitely a client-therapist relationship if that's what you mean." Oliver described the relationship in this way, "I'd say we're sort of cordial co-workers."

When asked to describe the relationship with their therapist, all of the clients in the study reported their relationships as positive. Pedro said, "I feel like we have a really good, open relationship." Jean reported, "It's tremendously positive, I feel very safe with [my therapist]." Many clients, such as Anthony, emphasized the closeness of the relationship and their feelings toward their therapists, "I mean, it's been everything to me. She's exactly what I needed. She's been awesome." Henry said it this way: "I love [my therapist] a lot. She's been a huge reason for me getting to a healthier place." Warren described the relationship with his therapist as helpful but expressed some dissatisfaction with the lack of closeness. He remarked, "Well I don't know, I thought it was pretty good, not super personal. It almost seemed more professional . . . he'd help me out and stuff, but it wasn't super personal." Although it was expected that clients choosing to participate in a study such as this would express positive feelings toward their therapists, the degree of fondness and attachment described by clients was unexpected. This emerged as a prominent theme with clients and therapists.

As therapists and clients described their experience of the therapeutic relationship in greater detail, four main themes emerged. These themes provided a general framework for the story of the relationships. They were *Referral and Initial Impressions,*

Development of Therapeutic Relationship, *Shared Investment*, and *Emotional Connection* (see Table 3).

Theme 1: Referral and Initial Impressions

The first main theme, *Referral and Initial Impressions*, involved how the clients and therapists met and began the relationship with one another and any previous experiences that may have influenced the development of their relationship. Some clients

Table 3: Outline of Results Part I

- *Part I-Experience of the Relationship*
  - *Theme 1-Referral and Initial Impressions*
    - *Referral Process*
    - *Previous Encounters and Therapy History*
    - *Initial Impressions*
  - *Theme 2-Development of Therapeutic Relationship*
    - *Building Trust*
      - *Establishing Trust*
      - *Validation*
      - *Consistency*
      - *Respect*
      - *Genuineness and Authenticity*
      - *Challenging in a Positive Way*
      - *Acceptance and Nonjudgment*
      - *Listening and Feeling Heard*
      - *Use of Humor*
    - *Understanding Worldview*
    - *Balance of Power*
    - *Positive Change*
  - *Theme 3-Shared Investment*
    - *Therapist Investment in the Process*
    - *Client Investment in the Process*
  - *Theme 4-Emotional Connection*
    - *Caring Relationships*
    - *Positive Perspective*
    - *Liking Who I Work With*

were randomly assigned to their therapists, while others actively sought out the person with whom they chose to work. For many clients in the study, this therapy experience was their first. Some, however, reported having worked with a number of previous therapists. This theme yielded three subthemes: *Referral Process*, *Previous Encounters and Therapy History*, and *Initial Impressions*.

Referral Process

In this first subtheme, the referral process is examined. Seven clients reported intentionally seeking out or being referred to their therapist. Four clients indicated they were randomly assigned to their therapist. Two clients stated they were transferred from another therapist to their current therapist for a specific reason. Each of the clients who sought out their therapist, were referred, or were randomly assigned talked about personal crises or reaching a point where they just knew they needed help as their motivations for seeking therapy. For some clients, such as Donald, it was an immediate decision. After experiencing a crisis at work, he said, "At that point I really didn't see any options . . . I needed to talk to somebody in the worst possible way." Several, like Janet, indicated that they waited for some time before getting help. She said, "I thought about it for a long time before I actually did something about it." Some clients described their situation getting increasingly worse before finally looking for help. Roberto recalled feeling fearful and thinking, "'Oh, my God, I'm crazy now!' But it was something that I knew for at least six months that I needed to do . . . and it wasn't until I literally almost had a panic attack and I would consider it a mental breakdown . . . That's what kind of forced me to."

Some clients described feeling personally motivated to make changes. Pedro described his motivation as, "There was something in me that wanted the person that I was before." Scott reported, "Well, I asked for a therapist who was focused on giving me tasks to do . . . instead of just listening to what I had to say and that's who they put me with." Steven, who was finally referred to a therapist in his local community after having to drive three hours to the nearest VA Hospital for months to receive therapy, said, "It took me a few times of going in pissed off and using bad words, but I've been wanting therapy for a while, you know? I don't want to be out of work forever. I hate sitting around at home." Others, like Janet, wanted to help themselves and improve their relationships. She stated, "I knew I had to take care of me finally; and if I didn't, then I didn't know what would happen to my children, my relationship with my husband. I knew that I had to do something to take care of me so that I could be better for them."

Clients also talked about the emotional experience of getting starting in therapy. Most reported feeling some anxiety and trepidation about opening up and disclosing personal issues to a therapist. Clint, a transfer client who had had a good relationship with his first therapist, stated, "I was mad at first when I found out that he was leaving. Because we had built that rapport, we built that relationship . . . Yeah, they can read the notes and everything from him, but it's not the same, you know?" Some clients of color and clients who identified as sexual minorities described this as feeling particularly risky, especially when anticipating meeting with White or heterosexual therapists. Roberto, a Latino man, reported, "I was actually trying to be very tactful when I went in . . . And I remember telling [the woman making the referral] that one of the things I wanted, was I wanted a person of color." He went on to describe his initial feelings about being

scheduled with a White therapist whom he was told would likely be a good match for him.

> [The referring woman] kept on mentioning about the things that [the new therapist and I] had in common, you know – he's a man, straight, and it seemed like she left that he was White at the end. And I was very apprehensive about it. One of the things that I have come across here in Utah has been the whole victim/savior mentality from White folks. And that was something to me, I felt like I don't want to be in that situation, where I'm being seen as, "Oh poor guy, he obviously needs help, and here I'm going to come save the day." Because I felt like I've come across social workers, teachers who have that mentality. And to me, that's very debilitating. So I didn't want to deal with that. So, when she told me that he was White, I was very apprehensive, and I remember kind of just looking at her, saying, "I don't know…"

Six clients mentioned the significance of being referred to their therapist by someone they trusted. This seemed to establish some initial credibility for their therapists and set up a positive expectation on the part of the clients. Natasha, Warren, and Steven each commented on their willingness to trust their therapists based on their positive relationship with the person who provided the referral. Logan, a graduate student, explained that he was referred to his therapist by a former supervisor whom he respected quite a bit, "So, first of all, I think having been a referral; I was already ready to give him a chance."

In a final component of the *Referral Process*, four therapists also noted the influence of their clients' referral and how this impacted the process of developing the relationship. Clark gave a great deal of credit to his client's previous therapist, a trainee whom he supervised. He stated, "I'd been watching this woman, and the practicum student had been doing a really good job with her. So, I mean, it was a nice thing to walk in to." Hal also credited his client's referring therapist for "frontloading" the referral. He explained:

> She made the referral for him to see me and talked with him about my stance and interpersonal style as a therapist, and then I had a chance to meet him with the past clinician, So I think that helped because he felt like this just wasn't any referral, it was someone who may be a good fit, who has a history of being culturally sensitive.

Dinah noted that her client was transferred to her after his previous therapist left the agency. She reported that he "really liked his therapist before me, and he felt a little bit kicked out. I don't know what that did to his assumptions to begin with." Dinah said, "He's had long standing depression and anxiety problems, and he was pretty discouraged. I think it was a good idea to transfer, and then I have a pretty different approach from his former therapist, which was helpful at the time."

Previous Encounters and Therapy History

As the referral process was explored, clients and therapists also began to discuss important aspects of their individual and shared histories. The second subtheme under the *Referral and Initial Impressions* theme is *Previous Encounters and Therapy History*. This subtheme has to do with any previous encounters between clients and therapists mentioned in the interviews as well as any prior experiences in therapy reported by clients. Four client/therapist pairs in the study reported having some previous encounters with each other before starting their current individual therapy. One of these encounters was actually one-sided, as the therapist acted as supervisor for the client's previous therapist and therefore watched video recordings of the client's prior therapy sessions. Clark reported that his client was aware of his supervisory role and addressed it during their first session stating, "She has a bit of a wry sense of humor, so the first time she came in she said; 'Now you've got the live thing.'" He also went on to attribute some of

his success in forming a positive relationship to the relationship developed by the prior therapist, “Because she had a good relationship with her [previous] counselor, that translated over pretty quickly and it felt as seamless as a transition like that could feel.”

Two of the pairs with prior contact had actually worked together as client and therapist in a different capacity. Clint had worked with his therapist in couples therapy at the same agency some time before being transferred to her as an individual therapist. He stated that due to the positive experience with her as a couples therapist, he requested to be transferred to her once he found out his first individual therapist was leaving. Clint recalled, “I had already had a pretty good relationship with her through the couples counseling . . . and I requested [her] because of that relationship. I had worked with a couple of other counselors . . . and not had the best experience with them. So I requested her.” Jean first met her therapist when she was working with her daughter on adjustment issues related to a medical diagnosis. Jean reported initially forming a trusting relationship with this therapist and began working with her individually after her daughter dropped out of therapy, then continuing off and on for many years.

Selina described first meeting with her client outside of any mental health agency setting. She recalled randomly meeting him at an event sponsored by the local college GLBT office. Selina recalled several people crowded into a small space and simply striking up a conversation with him. She reflected on the meaning of this encounter and said, “We just kind of had a good connection from the beginning.” Selina continued to describe the next time she saw him:

> And then probably it was like several months after that he came into the counseling center and requested to see me. And so . . . my impression or recollection of what he said, was that he had a good impression when he met me, but that he also had heard from other of his friends that positive

> feedback from my work with them. So, then it made it easier for him to approach me to see him.

In relating their histories, 10 clients disclosed past experiences in mental health treatment with psychologists or other mental health providers prior to starting with their current therapists. For some, like Natasha and Anthony, these were positive experiences and helped in their transition to new therapists. Four clients, however, reported previous negative experiences that seemed to have some impact on their attitude when deciding to engage in therapy again. Warren mentioned his previous therapist who had a very soft approach but was reluctant to suggest things for him to do. He said, "She was more hesitant and almost like sometimes she was afraid of me."

Others described more upsetting therapy experiences that made it difficult to risk opening up to someone new yet again. In some ways, these experiences seemed to set them up not to trust. Scott related a story of being "dropped" by a past therapist and the impact it had on him saying, "He told me that he couldn't handle the stress of dealing with me basically. He said that it was causing too much stress in his home life, so he dropped me." He went on to say, "Probably the hardest thing was he was a counselor that specialized in treating people who didn't respond to therapy. So, I mean, I was his specialty!" Steven, a combat veteran, related his extreme frustration at being forced to see multiple therapists and constantly having to start over and retell his story while no one seemed to care:

> I went through therapist after therapist after therapist. They kept quitting and quitting, and changing jobs through the VA. And it's like every time I went to the VA I had to tell my story all over again and finally I went up there one day and I was ticked off, and you know I go, "You know what? You're the fifth fuckin' therapist I've had. I'm tired of this. What do you want to know? You want to start from the beginning all over again? What do you want me to tell you, huh? I have nightmares of Iraq, I'm

> searching for my kids, I'm always here, and I'm always there. I wake up like I just got out of the shower." I was like, "What do you want me to tell you? Hasn't anybody logged any of this in your computer? Can't you read about it? I have to go over all this all over again with you?" . . . I go, "I'm tired of this! I'm tired of seeing therapists! I'm tired of coming in here and I'm tired of explaining! And every time I come in here you want to start me on new medication!" It's like, "I'm not a fuckin' guinea pig, I don't want to start on all these new medications all the time all over again, you know?"

Previous experience seemed to set the stage for a number of participants in terms of what to expect in the therapy relationship. For those who related prior negative experiences in therapy, it was particularly telling that they would give the process another chance. This perhaps says more about their level of distress than anything else. Negative expectations about therapy, however, did not predict a negative outcome for participants in this study.

Initial Impressions

The third subtheme to emerge from the major theme *Referral and Initial Impressions* was *Initial Impressions*. This subtheme centered on the initial impressions participants developed about their therapy partners at the outset of treatment. Therapists in this study rarely addressed any initial impressions they may have had regarding their clients at the start of therapy, other than remark on their level of distress. Clients, however, commented quite a bit on their first meeting and their therapists. I was not surprised to learn this, as the therapy encounter tends to be a unique experience in the lives of clients, whereas therapists typically maintain relationships with several clients at the same time.

Many clients in the study talked about having positive feelings toward their therapists from the very start of the relationship. As mentioned in the previous two subthemes, in some cases this was facilitated by past therapy experiences. For others it was a more drastic shift. Several clients talked about feeling an immediate connection or simply a "good vibe," as Steven put it during the very first meeting. This often came out in statements like this one from Steven, which is particularly meaningful given his statements above regarding past frustrations:

> I kind of like got a good vibe from him really quick. From the very beginning he had a really friendly aura about him, and it just happened really easy with me and him. It felt like almost like we knew each other already - like we could have been friends already. And I was just like, "I like this guy!" I left his office and I [thought] to myself, "I like [this therapist]!" I got a whole bunch of his cards and I gave them to all of my friends.

Anthony explained his experience starting up like this: "At first, [my therapist] wasn't going to take me on as a client. But I think we both liked each other and she adjusted her schedule and we've been meeting every week for 14 or 15 months . . . I just think we connected." Natasha also talked about how, during their initial session, her therapist seemed like "a person I was able to open up to right away." Donald remarked that, as soon as he began talking to his therapist, "there was really a connection." Pedro explained something important that happened at the end of the first session with his therapist that seemed to initiate the connection for him. "I kind of replied [that] I wanted to know ways to work on my weaknesses and since that moment, she gave me pretty good advice."

This strong feeling of connection was even mentioned by clients who admitted to some initial hesitation to engage in the process. Clint, who, as mentioned above, was

transferred to his therapist after having to terminate with a trainee, reported feeling "a little bit of nervousness to how she was going to react and how I was going to react to the different therapy styles." He also said, "The nervousness was gone after the second meeting. That's when we really made that next step of putting it how it is and working really well together." Roberto, who identified as a man of color, disclosed having significant concerns when he found out he was matched with a White therapist. He explained what his therapist did in their first session to immediately facilitate a connection. "When he put it [race] on the table, it really surprised me, and you know, I thought it was a gutsy call, and I really appreciated it. And I think that's what really started it."

It is interesting to note that, in addition to their initial concerns about entering into a therapy relationship, both Clint and Roberto expressed similar initial motivation for taking part in this study. Each of them reported wanting to somehow acknowledge the good work of their therapists and saw this study as a way to do so. Clint said he hoped it would allow more visibility of "the exceptional work [she] does . . . and give her more recognition." Roberto stated, "I'll be honest. When I saw [my therapist's] name on [the recruitment flyer], that's the least I could do for him."

It seems clear that the referral circumstances, therapy history, and initial impressions experienced by clients and therapists had a significant impact on many of the therapy relationships described by participants in this study. The ways in which clients were introduced to the therapy process and to their current therapists often set the course for the development of the relationship. The next theme deals with what happened after

the initial encounter and how the therapy relationships developed between clients and therapists.

Theme 2: Development of the Therapeutic Relationship

The next major theme that emerged from participants' experience of the relationship was *Development of the Therapeutic Relationship.* On the whole, clients and therapists interviewed for this study described their therapy relationship as an essential aspect of their therapy experience. Although clients based their judgment of the relationship on their immediate experience, therapists most often characterized the quality of the relationship in terms of their perception of clients' experience and progress. Therapists discussed their general approach to therapy and therapy relationships and also addressed specific interventions they used with the clients in this study.

They each described in detail the process of building a close, trusting relationship with their therapy partners. For some this process seemed to unfold in a fairly straightforward and comfortable manner, while others encountered challenges along the way. In examining the descriptions of this process, four common subthemes emerged *Building Trust*, *Understanding Worldview*, *Balance of Power*, and *Positive Change*. Under *Building Trust*, nine additional subthemes emerged: *Establishing Trust*, *Validation*, *Consistency*, *Respect*, *Genuineness and Authenticity*, *Challenging in a Positive Way*, *Acceptance and Nonjudgment*, *Listening and Feeling Heard*, and *Use of Humor*.

Building Trust

The first subtheme under *Development of the Therapeutic Relationship* was *Building Trust*. All of the clients and therapists interviewed spoke about the importance of building trust as a foundation for their therapeutic relationship. Clients shared their experience of coming to trust their therapists. They described the things their therapists said and did that allowed them to open up, take risks, and be vulnerable. Therapists also shared their process of developing trust in their clients and demonstrating their own trustworthiness in the context of the relationship. In many cases, clients and therapists seemed to agree on strategies and events in therapy that facilitated building trust. Some clients, however, described personally meaningful incidents that occurred in therapy of which their therapists seemed unaware.

Nine further second-level subthemes emerged from *Building Trust* that captured the experience of how this was accomplished from the points of view of both clients and therapists. These were *Establishing Trust, Validation, Consistency, Respect, Genuineness and Authenticity, Challenging in a Positive Way, Acceptance and Nonjudgment, Listening and Feeling Heard*, and *Use of Humor*. These nine subthemes did not emerge as discreet or mutually exclusive categories. In fact most participants commented on the dynamic nature of the therapeutic relationship and how multiple subthemes interacted with one another to affect the experience of both therapist and client within the same dyad.

Establishing Trust

The first second-level subtheme to emerge from *Building Trust* was *Establishing Trust*. The most fundamental element of the relationship mentioned by both clients and therapists was the ability to engender and develop trust. A common thread that came out as therapists described their perception of their clients' experience of the relationship was trust. Each therapist emphasized the client's ability to develop trust in the relationship as a key element in the relationship itself and in making progress toward therapy goals. Therapists attributed the strength of the therapeutic alliance to the degree to which clients felt this trust to be present.

Therapists reported trust in them and their ability was important in allowing clients to feel safe in the relationship. They mentioned clients' expectation that therapists demonstrate knowledge and skill in addition to sensitivity in order to build trust. Kara described it in this way:

> I think she trusts me to know enough to help her, to be wise enough to be careful while I'm helping her, to step aside most of the time as she determines the therapeutic goals, and to be respectful of her need to determine that. I think she trusts me with those things.

She also emphasized the strategic use of self-disclosure and her ability to demonstrate a good knowledge base as helpful factors in facilitating her client's trust.

Trust was also closely tied to the idea of client comfort level in the relationship. Diana characterized her client relationship as one based on "mutual trust and respect," which was established early in the therapeutic relationship through her use of empathy. She also expressed a sense that her client has "become more comfortable with me and my style so that I can use techniques that maybe I would have been a little more hesitant to use in the beginning." Dinah described her client's assertiveness in providing feedback

on their therapy sessions, “I hope that’s a sign of trust. I mean it’s utilitarian too, he gets more of what he wants when he tells me. I think he’s pretty open telling me what’s on his mind. I think he’s pretty square up about concerns. He really likes to be able to trust people.” Arthur reported the importance of his client’s trust as well as his responsibility to “live up to that trust” and work at maintaining it as the relationship progressed. He also noted his appreciation for clients’ willingness to place their trust in him:

> It takes a certain level of strength to be able to just even come in and talk to somebody that they don’t know, and certainly a level of trust that I haven’t necessarily earned. In fact not even necessarily - that I *haven’t* earned up to that point . . . I’ve been in plenty of therapy myself, so I know what that feels like, and it’s hard.

A number of therapists commented on the fact that trust often takes time to develop. Selina noted that this trust is often a “gradual thing” that typically takes more time for clients to develop in cross-cultural relationships, particularly when the client is a member of a historically oppressed group. Dinah said of her client, “He emails me when things are rough. I think he trusts me a lot . . . But I think it was cautious to begin with, with a little bit touch of gratitude in there, because he felt like it’s important. He’s become more trusting in my experience of him ever since.”

Hal also mentioned this in relation to his client, stating that clients who are members of minority groups may approach the therapy relationship with therapists who represent majority groups with some trepidation due to past experiences of oppression and discrimination. He described the process he typically goes through when addressing this with clients:

> I bring it up in session if it seems it’s relevant, which it often is, particularly building a relationship in the first session or two, and it may come up like me just asking the question, “How does it feel to talk with me?” . . . With this particular client, if I can remember, I think I’ve asked

> questions throughout therapy, but particularly in the beginning, "What's it like to talk to someone like me who is White, has power. I'm aware of my power, my privilege, and I'm aware that this is a risk for you to be as transparent or vulnerable with me." So I kind of would name that and then invite them to say, "Does it feel weird? Does it feel fine?" Then I can just kind of gauge, are they minimizing it? Are they using it as an opportunity like, "Yeah, this is freakin' weird!" or are they dismissive of it. And with him, I think it was pretty central to our work because, again, he's really sensitive to that. He was probably sizing me up fairly early, which is wise, like "How much can I trust this guy?"

Hal went on to explain what he sees as his responsibility to address differences as a way of building trust:

> I need to name it before they feel like they have to name it, because I think it's my job to name it. I feel like it helps them recognize that I have an awareness of this, and then bringing it up early. I think it just helps with my particular style of interpersonal therapy. I need to build a relationship first in order to go anywhere in terms of interventions and helping them and helping them move forward. So I have to make sure that my relationship is somewhat strong otherwise all that stuff is empty interventions because they're not going to trust me, they're not going to take me serious.

All 13 clients interviewed mentioned trust as a necessary part of their therapy relationships. This was the most prevalent sub-theme to be discussed in regards to clients' therapy experience. Each described feelings of trust, comfort, or safety in the relationship with their therapist. This subtheme seemed to capture a few different aspects of trust for clients. Logan talked about the experience of "absolute trust" felt in the therapy dyad. Pedro related feeling that, "When I talk to her, there's like a trust circle, like [my therapist] would say, so I feel more open with her than anybody else, I guess." When describing her therapist Natasha stated, "He has been the one person I actually can trust and believe in, in Utah."

Other clients talked about the process in which they developed trust in their therapists. A few, like Logan, mentioned entering into the relationship with a readiness

to trust after being referred by a trusted friend or another professional whom they trusted. Others discussed things in the relationship that facilitated trust. Scott remarked, "What I like about her is she always gives me different things to try to help with the depression and stuff so, so we talk about that . . . there's nothing that I don't tell her that I feel like I should tell her." Jean reported that a strong factor contributing to her development of trust was "because over a long period of time, she never let me down." Janet talked about how her trust was earned, "because the things that she's given me have worked and are working, so as I'm doing those things and implementing them into my life, I'm eager for more things that are going to work and help me."

Clients such as Roberto also referred to feeling "comfortable" and "open" with their therapist. They spoke about the ability to be open and honest in therapy sessions, and, as Janet explained, having therapists not "take lightly the things that I'm sharing." Pedro struggled to explain this feeling, "It's just sometimes you feel comfortable with somebody. Sometimes you don't feel comfortable around other people, you know, and she's one of those people that I feel comfortable with. I don't know how to explain it." Clint attributed it to "just having that honesty and . . . that open-mindedness, and the openness with each other has been the real kicker in making things really, really work well." Logan stated that, compared to other counseling experiences, his current therapist is "just more my style."

Clients also discussed trust in their therapy relationships in terms of a feeling of safety. They spoke about feeling safe from emotional harm and feeling secure that the information they shared remained confidential. Henry referred to his therapist's office as "the safest place ever," a place in which he could talk about anything without worrying

about being hurt or rejected. Jean, a long-term therapy client simply stated, "I just never ever felt so supported, and so safe with someone . . . I just feel so safe with her." Anthony, speaking with great emotion about his therapist, described his experience in this way: "I think she's always been protective of me. She was meeting with my dad for a little while at my request, and her concern was always about me, so I always felt protected, I guess, that whatever I told her, it was safe."

When discussing how they came to trust their therapists, four clients described feeling somewhat cautious at the beginning of their therapy experience. These four were clients in therapy pairs that contained two or more meaningful differences in demographics, statuses, or identities. They were also clients who reported having negative therapy experiences with past therapists or other mental health professionals. Logan, Scott, and Roberto each admitted to some initial testing behavior during the first couple of sessions to establish trust around differences. Roberto described his process of testing and developing trust:

> At first it was kind of difficult . . . instead of like putting things on the table and letting him analyze it and kind of giving it back to me, I was kind of like spoon feeding him, just a little bit at a time, just to see. And when, after a few sessions I felt like you know, I felt comfortable enough where I could just be completely honest, and just put it all on the table. But it took a while, it took some work . . . I wouldn't necessarily call it a challenge, but just at first it was more on my part, that apprehension of talking to not only a stranger, but a stranger from a different background, about the most intimate and deep and personal issues … and I think that I was putting too many walls with [my therapist] at first that it was almost like I wanted to research him first before I can open up. And that's why I don't see it [as] more of a challenge because it was just a matter of time, and I was able to just take them down and just be honest with him. But that would have to be the closest thing to a challenge, was just being, I want to say, somewhat mistrusting at first. You know, because there's always that fear of what they're going to do with that information . . . Yeah, I was investigating him. I mean to the point where I even went and did research on him on the website on the counseling center, because I

> wanted to know as much information about him, to see who this guy was. You know I was like, "I want to know who this cat is before I get involved with this guy."

Warren reported trusting his therapist's experience despite feeling a somewhat impersonal relationship. For him, the fact that his therapist was significantly older than he was and had been practicing for quite some time seemed to help overcome some challenges in the relationship. He said, "We would talk about maybe where the problem was in my thinking or my actions, or just anything, and he would help me find the solution." Warren further explained, "And even though sometimes maybe it seemed rehearsed, or the experience in him was coming out, it was a good thing because I could trust that he knew what he was doing, and what he was saying made sense to me. So there was some security in that."

Finally, in speaking about trust, one client, who also happened to have some training in counseling, made an interesting observation about the interaction between trust and differences in the therapy relationship. Logan discussed his experience of being in the role of both client and therapist in cross-cultural therapy relationships and addressing differences. He noted that, for him, if the foundation of trust is already present, that may be enough:

> I think the number one thing that I've learned through this is that those conversations about the differences between us aren't necessary if there's already enough trust. I'm a big proponent of open dialogue, but if we're already on the same page, then we don't even really need to have that talk, I don't feel like.

As the basic foundation of trust was discussed and clients expressed a willingness to take the risk of trusting their therapists, several other key elements were brought up.

These elements were identified as playing important roles in facilitating trust in each of the 13 pairs. They are detailed below.

Validation

The second subtheme under the theme *Building Trust* was *Validation*. The idea that clients felt validated or supported by their therapists was another recurring theme in therapists' evaluation of their clients' satisfaction of the relationship. Barbara speculated, "I would guess he wouldn't come back if he didn't feel some support." Other therapists reported the importance of clients feeling validation and responding to empathy in the relationship, but also seemed to minimize their own role in establishing this as demonstrated in the following quote by Diana:

> Although the fact is, he was really hurting when he came in to see me initially, and I think at that time, even if I hadn't been as client-centered as perhaps I am, I think anybody who was just responding to his pain, I think that would have been the beginning of a foundation for a relationship, a therapeutic relationship for him.

Clark described a situation in which his client who was not used to feeling validated in significant relationships with men in her life responded to any "demonstration of warmth or . . . empathy . . . I mean even just accurate reflection would be pretty meaningful to her." Validation around the pain and distress that brought the client to therapy was a critical part of the development of trust as exemplified by this statement from Hal:

> I had a sense that . . . when I helped contextualize with him some of the stressors and multiple demands on him that have kind of coalesced to create some difficulties . . . I think that was helpful in a way that he felt more validated.

When clients and therapists related the experience of providing and receiving validation, they did not refer to it in terms of single instances. Clients seemed to experience continued feelings of validation over time. This idea of consistency was identified and discussed explicitly by some therapists and is explored in the next section.

Consistency

The third second-level subtheme under *Building Trust* in the therapeutic relationship was *Consistency*. Four therapists highlighted their clients' experiences of feeling consistency and stability in the relationship as an important part of building trust in the therapeutic relationship. Helena described the impact of consistency in her long-term client relationship:

> I think that the biggest thing would be just the consistency and how long I've known her, and how often I've seen her over the years. I don't know that . . . most of us in our lives necessarily have relationships that last that long outside of our family members, you know?

Bruce described himself as being a "stable point of reference" for his client. He emphasized, "Even when the turmoil is happening . . . I've stayed there and been a constant. If nothing else, I'm that." Barry stated, "I'm always here." He went on to emphasize this point by saying that from his client's perspective he is, "always in the same office, looking about the same, and offering about the same kinds of services. I think he certainly knows what he can expect and knows that I'll be there for him in a consistent way . . . I think that's a big piece." Similarly, Dinah mentioned, "I never give up on him, I'm really born an optimist, and sometimes I wear people out with that, but it's been just enough with him, or we've worked it out back and forth – that I keep having hope for him . . . He knows I don't give up on him."

Respect

Just as trust, validation, and consistency were identified as important in the development of the relationship, *Respect* was the fourth subtheme to come out of *Building Trust*. Feeling respect for one's therapy partner was found to be a common factor in many of the pairs, and was mentioned by both clients and therapists.

Over half of the therapists in the study brought up specific feelings of respect for their clients. This was expressed and demonstrated in different ways. When describing the relationship with his client, Arthur spoke about a mutual respect saying, "It feels really easy to talk to him and I respect the way he thinks about things, and I feel like he respects me." When explaining her thought process around preparing for this interview, Helena reported discussing some concerns with her client about confidentiality and her desire to "make sure that I was respecting what [my client] was willing to have me talk about and not talk about."

Respect was often mentioned in relation to the life circumstances and experiences of clients. Therapists shared a deep appreciation for challenges their clients had overcome. After having observed a trainee work with his client prior to starting with her, Clark commented on having a "built in real respect for this woman." He explained, "I'd seen what she'd done with her life and she's a real hard worker, a good student, and you know, I respected that." Barbara reflected on the many responsibilities and "hard-working nature" of her client saying, "I just respected that about him, that he's very earnest . . . and hopefully he had a sense that I was very interested in him and respected him."

Over half the clients in the study specifically mentioned the respect they feel for their therapists. When discussing his relationship with his therapist, Henry mentioned, "I have a very deep respect for her." Clients also reported respecting their therapists' knowledge, education, and skill. Clint stated, "She's somebody that I do respect because her insight has been extremely helpful. And with some of the other things that she does, other kinds of counseling, [she's] somebody I can look up to." They also expressed a real respect for their therapists as people. Natasha commented on the way in which she speaks to her therapist, stating that she is mindful of the way she presents herself to him and the language she uses, out of respect for him. In speaking about the respect he feels for his therapist, Logan shared the following incident: "He's only once ever told me he was disappointed in me, and the behavior that he told me he was disappointed that I did, I never did again . . . It carried a lot of weight and . . . I was really invested in doing the right thing by him."

Respect for therapists as a part of the relationship development process seemed to go hand in hand with clients' experience of their therapist as genuine. Clients appeared to have greater respect for therapists who were perceived as genuine. This idea of genuineness is discussed in the next subtheme.

Genuineness and Authenticity

The fifth subtheme under *Building Trust* was *Genuineness and Authenticity*. The level of genuineness and authenticity of therapists in the therapy relationship came up with both therapists and clients. Six therapists talked about purposefully trying to be genuine with their clients. Each acknowledged the importance of allowing genuine

reactions in session and being personally congruent. Each also portrayed it as an active process. Oliver, a psychologist who has worked in a number of different settings over the course of his career, described his process in this way, "I try to be quite friendly and open in what I say, and do very little censoring of what's going on inside. And so, I try to be completely authentic in what I say." Donna linked being genuine with her client to the idea of being invested in the relationship:

> One thing is that I'm very genuine with them, and very authentic, and very invested. I don't sit back and say, "Oh, it sounds like you're feeling x, y, and z." And I'm really transparent with them, and very validating. Like whatever they say, they know they're not going to be judged, I give that…I create that environment in the relationship.

Another therapist, Selina, described being genuine as both a purposeful activity with clients and also as a more global value in her life. She stressed the importance of being congruent and allowing her clients to know what she is feeling in the moment, especially toward them:

> I think that there's a few things that I do that are very purposeful. One of the values that I have, I think, both as an individual and as a therapist is to be very authentic, very genuine, and very honest; and I keep those values very present in every single interaction with my clients. I am a very sensitive individual, and I purposely let my clients impact me, and I genuinely care for them.

Clark explained it in terms of transference, "I really think that transference where she perceived me as warm and inviting made a big difference." However, he also acknowledged the importance of his own role in creating this dynamic: "One of things that I do fairly well as a therapist is form relationships pretty well."

The feeling that their therapists were genuine and authentic with them in the therapy relationship also came out in a number of client interviews. This seemed to be an important factor in building trust with clients. In describing the traits she valued in her

therapist, Natasha stated, “That’s what I really like in him. He’s very genuine. I really appreciate that a lot coming from a counselor. That means a lot to me.” Logan shared a time in therapy when, after disclosing some intensely emotional things, his therapist looked at him and said, “‘I’m really sorry that happened to you.’ . . . it was the first time I’ve ever had a therapist use such a simple, sincere intervention. And it was pretty profound. I could tell that he was really sorry that what I was talking about had occurred.” Henry, who endorsed a particularly close rapport with his therapist, explained the personal importance of authenticity:

> I think my favorite thing about [my therapist] is just how authentic she is, and she brings her whole self to therapy. If she’s having a bad day she’ll tell me about it instead of just – I mean she doesn’t take up more than 5 minutes talking about herself ever – but, I know vaguely where she’s at so it doesn’t feel like I’m talking to a brick wall, like she’s a real human being, actually…shares stuff going on in her world. Like, she went on vacation and came back, she told me a little bit about how it was; it’s nice to have that kind of interaction so I’m not just dumping everything all the time, and being like, “I don’t even know who you are.” Basics, you know? It’s nice to know the basics of life - I appreciate that.

Challenging in a Positive Way

Building on genuineness and authenticity in the relationship, the next subtheme to emerge from *Building Trust* was *Challenging in a Positive Way*. As the foundation of trust was growing in the therapy relationships described by clients and therapists, the strategies used to challenge and confront clients became important. Several therapists mentioned the need to confront clients in a gentle way and the difficulty this entails. They discussed the challenges involved in having to bring up issues that their clients may not want to hear or talk about in way that is nonthreatening. Arthur stated, “I tend to say things in a pleasant way, but I don’t always say things that are comfortable for people to

hear, or that feel good to hear." Hal expressed the difficulty and complexity of challenging his client when necessary in a way that does not damage the relationship. He said, "I tried to challenge him, as well as support, acknowledge and validate where he's at," while also being mindful that by challenging his client, he may be perceived as "being incongruent with how he was experiencing me as this kind of supportive, trusting, therapeutic advocate for him."

This difficulty was also discussed by Selina, who reflected on her role as a therapist saying, "Part of my job is to be able to help this individual understand all of the pieces that are contributing to what's happening in life." Selina continued to discuss her internal process around challenging her client:

> Those have been some of the challenges, because I want him to know that I care about him, and that, you know, sometimes the things that might feel threatening from my part are more my attempt to help him understand and you know, get, whatever he needs to be able to function better, and do better.

Similarly, Kara remarked, "I feel like I have a job to do. She came to therapy to deal with her [presenting concern], so I bring it up and we look at it, and I make her look at it, but I also realize it's her issue and her timeframe, and I've got to respect that, too."

About half of the clients in the study discussed their therapists' ability to challenge them, often on difficult subjects, in a gentle, positive way. Janet said her therapist, "Puts me at ease . . . even when there are things that are hard that we have to talk about . . . I trust what she has to tell me." Some clients also mentioned the importance of honesty and directness in their therapy relationship. Henry was more to the point in his description, "She can call somebody on their shit in a really gentle way!" He also remarked, "Her challenges to me are unlike anyone else in my life. I mean, she's

my therapist so she's supposed to challenge me, but it's done with such gentleness and care and really sincere compassion." Clint explained the way he appreciated being "called out" by his therapist and recalled this example:

> There was one point where she basically said, "You know, I don't want to hear what you think I want to hear. I want to know what you're thinking, what your voice is, what your opinion is." And there was one point where I just flat out said, "I feel like I should tell you it this way, to please you, but I'm not going to. This is how I truly feel and really feel about it."

Challenging clients in positive and gentle ways was identified as a critical part of the therapy experience by a number of participants. Several clients reported that this facilitated growth and positive change. The ability to challenge clients also depended on an atmosphere of acceptance. Clients were better able to deal with being challenged if they felt safe from judgment in the relationship. The following subtheme examines this.

Acceptance and Nonjudgment

Acceptance and Nonjudgment was the seventh subtheme under *Building Trust*. All therapists in the study brought up acceptance and nonjudgment as an essential piece of creating a positive relationship with clients. This was perhaps the strongest theme in the therapist interviews in terms of fostering a trusting therapeutic relationship. Barbara explained it in terms of providing a "nonjudgmental and respectful place" to talk and feel accepted. Donna commented that "fundamentally, I just want them to be able to trust that they can say whatever they need to say, and that I'm not going to judge them about it." She stressed that the therapy relationship "might be the only place that they can say whatever they need to say."

Some therapists connected this to their overall approach to therapy clients. Oliver stated that an important goal for him in therapy is "unconditional acceptance of my client." He further explained that "unconditional acceptance of human beings" is a critical aspect of his theoretical orientation and, "even people that do things I would think of as being deplorable, I would say that's not them, that's some nonsensical or perhaps selfish idea that they have, but they are not their ideas." Other therapists related the idea of acceptance and nonjudgment to their greater sense of themselves in relation to others. This was evident in Kara's comment on her personal attempts to develop acceptance of others: "Accepting of myself and all my flaws and all my experiences, good or bad, whatever they are - this is life . . . accepting that in myself and accepting that in the other person." She went on to say, "I think it creates . . . valuing of the other person. And it creates an acceptance of their life experiences without judgment."

Diana related how allowing her client to talk openly and without judgment about ongoing personal challenges contributed to their relationship. She explained, "A lot of times, people feel humiliated or embarrassed, so to know that you can get through those things together I think is very important . . . to continue to strengthen that relationship; that I'm not going to abandon him or be disappointed in him." Bruce described the importance of acceptance while initially building a relationship with his client, whose "guard was pretty darn high:"

> He had an agenda. He was going to tell his story and I think he was waiting to see how I'd respond. And even though he was asking to be fixed, "Come on, I'm here to be fixed, fix me!" had I tried to fix him, I knew that it would go badly. So the real thing was to see if I would be human with him. I really believe that he wanted to see if I could meet him on a human level and that he's not a disease to be cured. Which I think his perception at least . . . was people are trying to cure me from being me.

Dinah mentioned the impact of simply being open to her client's interests and having a willingness to learn from him without judgment: "I'm curious about his music, and that's become our kind of tradition that we talk about on the way back [to my office] . . . I write down the tunes he's told me, and I listen to them . . . I learn a lot about him . . . and it's two minutes on the way back to the office." Oliver related the importance of acceptance and unconditional positive regard as an "article of faith" and linked it to respecting clients as equally valuable and knowledgeable human beings. He expressed some frustration with other approaches and other colleagues that seem to elevate the therapist to the status of "guru" and devalue the client in the relationship.

> We take ourselves very seriously, and I don't like that. What we do, it's not magic. We are not Gandalf. Our clients are not Hobbits. We're not doing magic. We're engaged in some kind of a persuasive exercise even if we don't believe we are. And we're all of us screwballs. Every human being on this planet is a screwball. The goal is to be less screwy, but that's what we are, and I think that makes it easier to do your work if you say, "Well, I'm a fallible, flawed human being; my clients are fallible, flawed human beings," and many of these clients know stuff I won't learn. Engineering students, math majors, if the situation was reversed I'd want them to treat me respectfully, and I could learn from them. I can learn the most important things which is what their dilemma is. And so that's unconditional, regard of the other person. And I try to have that, and I do hope they'll laugh at my jokes. But, if they don't, it's usually a problem of timing and match and I haven't matched up, as much as it is in them not having a good sense of humor. Of course, if they don't have a good sense of humor I'm going to run into a brick wall. But why isn't that just an interesting challenge?

"I appreciate that she knows me well and loves me anyway." This quote from Jean expressed a sentiment that several clients brought up – the feeling of unconditional acceptance from their therapists. Clients talked quite a bit about not feeling judged or "analyzed," as Natasha put it, in therapy. They also made comparisons to past negative experiences with mental health providers. These clients also stressed the enormous

impact this had on their ability to open up and experience a trusting relationship. Steven stated, “I don’t feel like I’m judged when I go in. That’s why I like him so much, because I don’t feel like I’m being judged. I don’t feel like he looks at me like I’m a different person than him.” Another client, Donald, compared his current therapist with a psychiatrist he had seen in the past, stating that his therapist “takes me for who I am and tries to do the best with what I got, rather than trying to change me into somebody else.”

Natasha spoke with great intensity about the nonjudging approach taken by her therapist. This client, who identified as an active member of the Church of Jesus Christ of Latter-day Saints (LDS, or Mormon, Church), talked about the acceptance she felt from her therapist as a spiritual experience. She compared seeing her therapist to meeting with her LDS bishop without the risk of being judged or disciplined for things she chooses to disclose. In perhaps the highest compliment any client in the study paid a therapist, this client described how meaningful the kindness and acceptance of her therapist has been in the following way, “I think that for me he is like Christ or my Heavenly Father.”

Listening and Feeling Heard

An essential piece of feeling accepted and allowing oneself to trust is the experience of truly being heard by another person. The eighth subtheme to come under *Building Trust* was *Listening and Feeling Heard*. Active listening was another important aspect of creating a positive trusting relationship with clients. Most of the therapists noted how effective this basic skill was with each of their clients regardless of the circumstance. Barbara said, “I did a lot of listening,” and “he mostly just wanted a place

to be listened to and heard, and I was quite happy to do that." Bruce described how simple yet effective it can be to listen and reflect:

> Yeah, it's easy in the sense that all I had to do was back up and [use] reflective listening. "This is what you said," couched in my own words, and "This is what I'm hearing prompted you to say something like that." And when those things connect, that's when he's starting to feel really heard, not just a superficial, "Oh, yeah, you heard the words I said," but to really feel genuinely heard. And then the defenses slowly come down, and then the tears come.

Barbara further reflected on the quiet power of listening, not only for clients, but also what role this foundational counseling skill means to her as a seasoned therapist:

> Sometimes, if I ever have any performance anxiety after 28 years, which once in a while still comes up, I think, "All I have to do is just listen." I know how to do that. Here I am worrying that I have to do something, just listen and hear who this person is and that puts my anxiety down in a quick hurry.

A number of clients brought up the importance of their therapists simply listening to them, and allowing them to feel heard. Pedro mentioned his appreciation for the balance between problem solving and listening that his therapist exhibited saying, "Sometimes I don't want her to solve my problems, I just want her to listen." Donald reported that sometimes his therapy sessions involve "just me venting," and his therapist has been able to normalize this and allow him to feel heard. Logan expressed admiration for the "quiet listening" his therapist displays, stating, "He waits until I've kind of let my floodgates open, the tidal wave has passed, and then he will pick up the pieces and put them together and find themes for me and connect them to previous sessions' themes and then he'll generate new insight with me."

Warren described some experiences of not feeling heard in therapy and the challenge this presented for him. He said sometimes he would come to therapy and, "It

was like I have a lot to say, but I only say one thing, and he just kind of jumped on that and tried to find solutions for that thing while my mind is still on a bunch of other things also." Warren stated that, although his therapist's guidance was very helpful, at times he felt like there was more he would have liked to express before focusing on solutions. He said, "It's almost like he'd hear something that he's heard before and he gives the response that he'd given many times before."

Use of Humor

One way to create a more relaxed environment in what for many can be anxiety provoking experience is employing humor. Breaking the tension or being irreverent without being disrespectful can also help to facilitate closeness and trust. The final subtheme to emerge from *Building Trust* in the therapeutic relationship was *Use of Humor*. A few therapists remarked on the use of humor or playfulness with clients as a way of building the relationship. Oliver stated, "I try to be just as funny as I can be" and stressed the importance of being "lighthearted" with clients when appropriate. He also remarked on the therapeutic value of helping clients find humor in their irrational beliefs, while still communicating respect for the person. Barbara commented on the role of "playfulness" in lightening the mood at the end of a session and also creating a more egalitarian relationship with her client. Clark remarked on how his client's "wry sense of humor" helped to create an immediate connection and establish a level of trust in their relationship.

Half of the clients interviewed mentioned humor as an important aspect of the therapy relationship. A few clients talked about both the use of humor by therapists and

the ability to joke about issues and be playful in session as a valuable part of therapy. Henry remarked, "[My therapist] and I laugh a lot, which is really great. I love the humor that is within our relationship. I love that that is such a big factor." Others noted the importance that their therapist understands their sense of humor. Anthony stated, "She understands my sense of humor better than my wife, because I'm not always couth, or whatever you want to call it. Maybe that's why we get along, because we both can swear!" Logan also explained his thoughts on the need for humor in therapy:

> I need my therapist to think I'm kind of funny. Not like I have a diaper fetish, but like thinks that I'm sort of adorable, you know, in that kind of way that you sometimes look at [people] and you go, "You are just such a cute little fucked-up man!" So I like that he gets when I'm being funny and he gets when I'm being sarcastic.

The process of building trust in the therapy relationship was discussed by each of the clients and therapists in this study. Participants stressed their experience of trust as the most basic foundation of the therapy relationship. They also emphasized the various factors that seemed to contribute to the development of trust in each pair. Establishing a trusting relationship was described as something that took hold quite easily in some of the pairs, while for others it was a more gradual process that occurred over time in the relationship. All of the participants acknowledged trust as a necessary dynamic in developing the therapeutic relationship, though not sufficient on its own. Clients and therapists reported three additional factors that also played critical roles in this process. These factors are represented by the following subthemes and include *Understanding Worldview*, *Balance of Power*, and *Positive Change*.

Understanding Worldview

The second major subtheme to emerge from *Development of the Therapeutic Relationship* was *Understanding Worldview*. When therapists and clients in the study described their experience of the therapy process, the importance of understanding the clients' worldview was identified as an essential component. For therapists, the idea of working to understand a client's worldview involved an attempt to truly comprehend how each client experiences and operates in the world. This encompassed everything from getting to know how cultural values and socioeconomic constraints impact a client's situation to developing a good idea of what her/his daily routine looks like. For clients, this meant truly feeling understood by their therapists. Some clients had not experienced this anywhere else in their lives.

Some therapists sought to understand how their clients live and interact in the world around them. Selina described this process in terms of her existential orientation to therapy, "It's really about understanding their phenomenological experience, you know? How has your experience shaped who you are and your values and your views? How [do] you relate to you and others and the world?" A number of therapists also acknowledged that this process involved exploring the context of their clients' lives. Arthur discussed his initial focus on trying to understand his client's "beliefs" as well as the role of his client's upbringing and culture in his life in an attempt to "understand where that all comes from."

This is not always an easy process, as Barbara explained the challenge of "just entering his phenomenal world and trying to understand." She reported being mindful of "how much of this am I getting? Because the intent was there . . . but [we] had a lot of

cultural differences and I wasn't always sure." Barbara went on to say, "I may never understand them perfectly, but understanding them I guess is my first goal." Diana described the role understanding her client has played in their relationship:

> I would think that one of the things that has strengthened [our relationship] is just really an attempt to understand his worldview and to approach him, not from what I think he should do or from what I need him to do or what I would like him to do, but what is really good for him, given how he manages in the world, how he approaches the world, who he is, and who he wants to be. In fact, one of the things that we've worked on in the past year and a half is him really becoming true to himself. So, in order to do that, I have to know who he is and we have to look at that and examine that together so that I can guide him appropriately. So I think really making an effort to understand him and get what it's like to be that particular person, who I am not, for lots of reasons . . . I think the world view has been important with that.

In speaking about his attempts to understand his clients, Bruce mentioned how impactful it can be to simply demonstrate his willingness to try, knowing he may never fully understand their experience. He described what this process is like for him when working with clients' with trauma histories:

> I have to find out from them what it's like to be them in a traumatic situation without pretending that I ever get it, because I don't. I can reflect and get a hint, a taste of what it was like, and I think that that feels really, really good for them. Because most people in their life don't do that, they don't even try and go there.

Kara described her process of developing an understanding of clients based on the context of their behaviors and connecting to the common human experience. For her, there seemed to be a sense of honor and respect around clients' experiences that she expressed in her attempt to gain understanding. She explained, "I just have this deep belief that most people are doing their very best; no matter how bad it is, people are generally doing the very best they can do, … and I think I bring that to my understanding

of people." Kara went on to connect her understanding of clients to her understanding of herself:

> I think the human conditions are pretty common . . . I think there's more we share than we differ in, by far. And I think there are only a few common human experiences and we can all connect to each one of those. I couldn't name them [all], but there is experience of connection and there's experience of betrayal and abandonment and rejection. And we all have those to some degree . . . I've got some ugly parts to me, too, so I'm okay with that! And if you're not afraid of connecting with yourself, then you can probably connect with the patients pretty well . . . I think if we accept and understand ourselves pretty well, we accept and understand the patients. I mean, to connect with them means to connect with myself.

Some therapists talked about the difficulty involved in understanding clients who happen to be different from them in a number of ways. Barry commented, "It's always a process, of course, to understand any client, but particularly those with different identities than my own"; and he went on to stress the importance of viewing this as an ongoing process throughout the therapy relationship. Barbara explained that for her, the differing identities with her client made the relationship more enjoyable:

> I think it would be easy sometimes if someone was less obviously different than I am on so many variables. It would have been easier just to assume I know what they're talking about. But I think it's been kind of nice that I could ask him questions and he seems to be willing to explain or answer them, and so his willingness to share some of that and my interest in it I think was always communicated, my caring and he's not just a number, he's somebody whose worldview I want to really understand . . . in some ways I really love in a kind of special way meeting with someone from another country, because I get to learn. I get my own world view expanded. So that makes it just an even more enjoyable experience, and I think that probably comes through in the relationship when I'm kind of really not just, "How do I fix your problem?" (laughs) but, "Who are you? And I would like to understand your experience."

Dinah commented on trying to understand her client and sometimes falling short in some way. She said, "I'm pretty square up about what I do and don't get. But especially by now, we've been meeting . . . it's been more than a year. And I try to get it.

Sometimes I've used metaphors that undershoot how serious it is." Dinah explained, "Once when I'd done that in a bad way, trying to make a point that I thought would help him . . . he was instantly mad. He told me about how invalidating that was of a thing to do." She reported trying to repair the relationship using self-disclosure and sharing a principle that helped her navigate through a difficult experience:

> And the way I knew that that thing helped so much, was that . . . I lived through the death of [a family member] with that thing, and it helped tremendously. And so it wasn't a small principle . . . when I was trying to help him get it, I didn't want to give him a tremendously heavy example and I didn't want to say my story - here's this death experience and have it be my therapy session. So I made the error of making a really small one, and then by way of repair I ended up telling him that, which is kind of a big thing to share with a client. And I didn't know how that would go, but I had so like slapped him in the face . . . And so I responded because it really does help in my life, and I really did want him to have something that would help . . . so he knows more about me than most people do – well, my clients!

Nine of the clients interviewed discussed feeling understood by their therapist as one of the most important aspects of the therapeutic relationship. Jean was very direct about this stating, "Something that I need as a client is somebody who understands me, who cares about me." Each client stressed the connection they felt by being truly known. Steven verbalized this by saying, "He knows everything I'm going through." Logan emphasized this point and phrased it in terms of his therapist being "onboard with my worldview."

Anthony explained his feelings about being understood as a "relief because I had someone I felt I could tell how I was feeling and they understood . . . it took a lot of the burden away. She was just someone I could tell everything to and she understood." Similarly, Roberto talked about how his sense of being understood was a critical element

in allowing him to open up. He found it particularly helpful that his therapist was familiar with the type of research he did as a graduate student and the specific paradigm through which he saw the world. "He was able to understand where I was coming from because of his own background. And that really allowed us to grow our professional relationship into a different level." He went on to say, "That really allowed me to open up and put a lot of my issues on the table without having to fear that he's not going to understand where I'm coming from."

Two clients also talked about how their therapists seemed to use their clinical understanding of them to help challenge them and call their attention to certain avoidant behaviors in session. Roberto noted his tendency to tell "long stories" in therapy and try to hide any emotional content. Roberto stated his therapist was able to see through the stories even when he did not want him to, and "bring me back to that story that I was telling within that [longer] story." Henry described his experience of this as follows:

> I feel like I consistently do that, consistently tell stories for the sake of humor or "You'll never believe how ridiculous this was," but in reality, "You'll never believe how ridiculous this was, because it really hurt." I tend to leave out the "it really hurt" piece of it and just tell the story. But I also think that [my therapist] reads into that, and she knows how I was feeling without me even saying it. But I think the challenge for me is saying it anyway. Even though she can voice back to me "I'm hearing you say ABC," I should just . . . I want to be able to say "I was feeling this."

A few clients discussed feeling that their therapists really had a good understanding of their everyday lives and what it is like to be them in the world. Natasha described it this way: "I can see in his eyes, he's trying to see me and where I was standing. And he's trying to understand where I'm coming from . . . he's trying to see me as me . . . see what I go through in everyday life." Two clients mentioned how

meaningful it has been that their therapists have some understanding of their struggles as a single parent and all the concerns that go along with that role.

Three clients mentioned feeling that their therapists had some difficulty understanding certain aspects of their identities that had to do with differences in the relationship. Each one expressed gratitude toward their therapist for trying to understand their lives, but acknowledged that some experiences may be beyond their therapists' ability to fully comprehend. These clients mentioned issues related to their sexual orientation, age, and religion. Scott was one of these clients. He discussed the conflict he experienced between his religious beliefs, his desire for a family, and his sexual orientation and how his therapist tried to be supportive but at times missed the mark. He shared, "I would talk about how much I wanted to …get married, have a family. And she would always go, "Well, there's benefits to not."… I don't think she quite understood how I guess lonely I am … and how much I wanted that type of relationship." Logan also commented on his therapist's inability to relate to certain aspects of "gay culture." Warren noted that his therapist seemed to have trouble relating to him at times due to the wide difference in age.

It is worth noting, however, that each of these clients still reported a positive, trusting relationship with their therapist. These clients stressed the value they saw in their therapists' sincere attempts to understand them. They seemed to overlook or forgive the misunderstandings due to the foundation of trust and the many other positive components in the relationships that had already been established. Two of these components are explored in the subthemes *Balance of Power* and *Positive Change* below.

Balance of Power

Balance of Power was the third major subtheme to come under the theme *Development of the Therapeutic Relationship*. A number of participants mentioned the balance of power in the therapy relationship. They discussed the give and take nature of their interactions and the shared responsibility for guiding the therapy process. Both therapists and clients commented on the difficulty of knowing how much structure and control was helpful. Seven therapists discussed their experiences with the balance of providing structure and yet allowing the client to lead in therapy. Oliver stated that he makes the client's role as guide quite explicit stating, "Each session is probably between eighty to ninety five percent its own thing," and typically starting each session by asking, "What would you like to work on, what might I help with today?" then focusing the session on whatever his client identifies. Hal commented that not having a set agenda with his client has "strengthened" their relationship by allowing his client "more space to be a part of the decision-making on what he needs from therapy, so he has some of that power." Others described this balance as more of a dynamic process. Helena pointed out that working with her client over the years involved "learning as a therapist that it's ok to let some people move at their own pace."

Some therapists discussed the tension between addressing their clients' presenting concerns and allowing them to determine therapy goals. Kara acknowledged this tension saying:

> If I get too forceful about setting her goals for her, yeah, I get resistance, which I probably deserve . . . And I do tend to get a little bit stronger with her, because I remember why she came to therapy and because I remember what her initial treatment goal is . . . Should I bring it up? I don't know. But it's her initial reason for therapy, so I keep bringing it to her attention.

Kara also admitted the importance of being able to "step aside most of the time as she determines the therapeutic goals and be respectful of her need to determine that." Bruce expressed the frustration that can come with this tension between setting an agenda based on his client's treatment needs and also empowering his client by allowing him to guide:

> So every single time, at the end of the session I'm sitting there perplexed. He's saying, "Couldn't do this session any better, it's the best I could imagine it to be." And I'm sitting there saying, "I didn't teach you a single coping skill, I didn't reorient you to your internal processes to become more aware of them." I failed miserably from a theoretical orientation standpoint. And yet, he keeps telling me I'm the best therapist he's ever had. So I'm always both pleased that I'm doing something for him and shaking my head at – man, I'm not doing what I want to do for him. So it's difficult . . . It's not even just on my mind either, I have it written down. These are things I'm going to do with him! . . . I have to keep reminding myself so I continue to trust the therapeutic alliance…that that is the foundation, and so I do nothing to jeopardize it. If I start doing anything that feels like he would begin to question my belief in him, I back off, which means I'm constantly backing off of doing what I think I ought to be doing. And so that is hard, but I really try and trust the therapeutic alliance. That is…because of course if that goes, then any technique I'm going to try anyway is going to fail.

Dinah, who identified as "behaviorally oriented" in her approach to therapy, described her process of allowing clients to direct the process. She said, "I'm really pretty forthright. I ask them what they want to work on and I take their word for it. And then I really try very hard to work exactly on that." Dinah also reported checking in with clients at the end of their session and asking, "'How are we doing? Is this what you want to be working on, do you feel like this is useful?'" In speaking of her client in the study, she said, "He'll tell me both things that were going well and things that were not." She reported that, on one occasion, her client informed her, "'You know, I think you told a story or two more than I wanted to hear.'" Dinah went on to say that if she wants to

move too quickly from listening to him to an idea of something to do, "he'll stop me – right then, or he'll tell me afterwards. And I appreciate that a lot; I think that's helped a lot. And I listen and I remember. So our task agreement is pretty good, our ongoing course correction is pretty good."

Dinah also highlighted the importance of basic symptom reduction. She emphasized that most clients are primarily interested in strategies to reduce their current level of distress. Dinah mentioned that this is a practical goal that she tries to be mindful of with her clients, saying, "What's not to like about that, you know? I appreciate my dentist when he can stop a toothache, and you know it's not the deep thing, but it helps, and we're a pretty good match for the moment for that."

Clients also had quite a bit to say about sharing power and being allowed to lead in the therapy relationship. This was an important part of therapy for Henry as he explained, "I feel like I definitely guide where therapy goes. You know I come in and talk and [my therapist] never has an agenda and there's never some checklist of things to talk about, it just . . . it's real organic." Several clients noted that their therapists allowed them to play an active role in determining therapy goals and session content. These clients expressed appreciation that their therapists did not dictate a specific agenda or follow what Henry called a "checklist of things to talk about" during their sessions. Anthony expressed gratitude toward his therapist for not pushing him to move too fast, stating, "She hasn't pushed me at all. She's let me go at my pace. She's understanding of how I feel. Normally I put pressure on myself to do certain things and I didn't feel her doing that." In discussing how he and his therapist have approached his most distressing trauma symptoms, Steven said, "He hasn't pushed that on me. Because some of it is kind

of like touchy subjects and stuff; so, he lets me talk about it as I feel comfortable. When I want to talk about it, he lets me talk about it."

A number of clients acknowledged the need to strike a balance between extremes regarding structure and strict agendas. They reported valuing some structure as well as having the freedom to set their own goals. With some clients, this seemed to tie into feeling respected as a person by their therapists. Donald recalled a psychiatrist with whom he had worked who had a clear agenda that he compared to "what they do with new recruits in the army . . . strip them of all self-esteem and then build them back up." He contrasted this to his current therapist's approach: "He never really pushed me to go where, at a deep level, I didn't want to go . . . he is respecting me as a person to deal with the issues that I bring him." Janet talked about how her therapist "will touch on what I came for, but that's not always what I need. I appreciate that she is willing to give me direction . . . sometimes we focus on what I've really come for, but other times, we focus on what I really need." Janet's comment mirrored almost exactly her therapist's remarks on the subject, suggesting they have acknowledged and discussed this balance of power directly with one another.

As therapists talked about the balance of power in their therapy relationships, a few of them brought up the importance of being open to correction and owning mistakes they make in therapy. One interesting pattern noted in this area was that therapists working in university counseling centers were more likely to talk about possible relationship breaches with study clients as well as other people with whom they worked. They also stressed the importance of acknowledging their part in any miscommunication or misstep as an opportunity to strengthen the relationship. Oliver reported encouraging

his clients to "correct me if I make a mistake." Donna discussed awareness of her personal limitations in working with certain value systems and how meaningful and even empowering it has been to address this honestly with clients. Clark spoke about his willingness to be "open to correction," emphasizing that this is especially important in regards to cultural issues. Reflecting on the work done over a number of years with his client, Barry said:

> I think our work has afforded me an opportunity to begin to try and develop my own kind of multicultural skills. He's also been forgiving of me when I've made missteps and, or, you know, just flat out errors. And he's very gracious and accommodating, and so he's been inviting and he's been kind of a good person for me to learn with.

Three clients mentioned feeling they could challenge or disagree with their therapists without fear of damaging the relationship. Clint stressed the importance of being honest and direct with his therapist, stating, "We call each other out on stuff and it makes it really nice." Scott spoke about the importance of being assertive and verbalizing his needs and preferences with his therapist. He said, "A lot of therapists, they just wanted me to tell them my emotions, and I can express my emotions to anyone; but I need help understanding them, learning how to control them . . . or trying to cope with it. And I need to learn life skills so that I'm functional." He reported establishing his goals at the very start of the relationship with his therapist, stating, "The first visit was I just gave her, 'This is what I've been working on, this is where I've been, this is where I'm at now, and this is what I want to work on. I was very to the point and 'Let's get going!'"

Jean, who emphasized her discomfort with confrontation, reported feeling as though she could be assertive with her therapist at times. She recalled a time in therapy

when she was mad at her therapist and said, “I was afraid to tell her, and she said, ‘You can be mad at me. It’s ok to be mad at me. We’ll work through it.’ And that’s a very foreign idea to what I grew up with.”

The experience of shared power in the relationship, in addition to trust and understanding, were endorsed as important interpersonal dynamics between clients and therapists that helped to establish a positive therapeutic relationship. The main reason for establishing this relationship is to facilitate movement toward the therapy goals. These goals typically involve change and improvement in some areas of the client’s life. A number of clients and therapists also identified the change itself as having a reciprocal impact on the therapy relationship. The impact of positive change is discussed in the next subtheme.

Positive Change

The fourth subtheme to emerge from *Developing the Therapeutic Relationship* was *Positive Change*. Many of the participants mentioned positive changes they experienced as a result of their therapy relationship. Clients most often mentioned changes in terms of progress toward therapy goals, decrease in distress, or better overall functioning. Therapists, however, also described personal changes they experienced from working with their clients. A number of therapists interviewed described engaging in a therapeutic relationship in which they allowed themselves to be personally impacted by their clients. Each of these therapists stressed the importance of maintaining appropriate clinical boundaries, but they also acknowledged the reality of their investment in the relationship as well. A few reported allowing themselves to

demonstrate genuine emotion with clients in session. Selina commented on her experience:

> I'm not afraid of, you know, crying in session with them. And I feel like that's important, because it's not about trying to make them think that I care about them, it is that I genuinely care about them, and so I'm not trying to pretend something, you know. I let them impact me and that I really care for them . . . I'm allowing that to come through. I think that I share, or disclose, parts about me when it's appropriate. I don't ever purposefully keep any parts of who I am as an individual, but I feel like who I am as a person and as a therapist are the same person. And I just sort of allow all of those things to be a part of the interaction.

Clark described a situation at the end of a particularly emotional first session for his client when he stood up to shake her hand and instead she walked over and embraced him. Although unexpected, he recognized it as a sincere demonstration of her appreciation and stated, "It was actually pretty meaningful to me."

While reflecting on their relationships with the clients in the study, three therapists reported feeling that their clients have helped them grow as professionals. They acknowledged learning quite a bit from the challenges and successes encountered in their work. Helena commented at length on the ways in which her client "helped to shape who I was as a psychotherapist."

This subtheme came up in all 13 client interviews. Clients spoke about the ways in which their therapy relationships helped them achieve positive changes in different areas of their lives, from immediate changes in mood or perspective to long-term changes in behavior and improvements in interpersonal relationships.

Anthony remarked on the change in his emotional state after therapy sessions, "I look forward to my weekly appointments. I always feel better when I leave." A few clients echoed his statement about feeling an immediate change in mood after their

therapy appointments. They stressed the emotional change they experienced, describing their therapy sessions as a turning point in their typical routine. Pedro shared, "I got really depressed and then I felt way better after our sessions, and even though I still feel better, you know, and feel happier than before." Steven, a client whose PTSD symptoms had significantly affected his mood and limited his psychosocial functioning, said, "When I walk out of his office I feel good. When I walk out of his office, I'm happy. I come home and I have a good day . . . I feel happy about myself and I feel confident. He makes me feel confident." Donald commented on the importance of learning something new in therapy, "I always come away with something that on my own I wouldn't have figured out."

A number of clients related how their therapists helped them improve in some way and make positive changes. Henry reported, "She's been a huge reason for me getting to a healthier place." Anthony said, "I think she makes me feel good about myself." As the quotes from Henry and Anthony imply, these clients expressed enormous gratitude and seemed to attribute these changes almost entirely to their therapists. The same clients, however, also acknowledged their own role in making substantial changes in their lives, as illustrated in later themes. This quote from Jean seemed to capture both a sense of empowerment as well as an acknowledgement of her therapist's role in the change process:

> I think she has made me braver. You know when she first knew me she said, "You were all of these different people depending on who you were with." I think [my therapist] has made me more comfortable to be me. And to actually stand in my own space, and defend, even if it's just to myself, the fact that I'm ok with who I am. And I don't have to be the right person for [others], but I can be an ok person for me and to know that's good.

When speaking about how helpful their therapy experiences have been, nine clients brought up how relationships with others in their lives have been improved. Some, like Anthony, discussed improved relationships with partners: "I think a big part was, you know, she understood me better than my wife did for a long time; and I think it's helped my wife and me, so that my wife understands me better." Others talked about improved family relationships. Janet related how her therapist helped her relationship with her daughter: "I know that she's struggling and she needs help, and I don't always know the best way to help her. So it's good for me to have somebody I can talk to and get direction so that I can help her in a better, more effective way." Henry spoke about how his opening up in the therapy relationship has impacted other relationships throughout his life:

> The more I open doors with [my therapist], the more doors open in my life, as well; and it's reflected. It's like as soon as I start talking about something in here, something that's like, I mean, I know the past couple of months I've started talking about stuff that I haven't talked with anybody about. And then it makes it easier to talk about it with my friends, or with my family, or with the other relationships that I have. It makes it easier to open up and be vulnerable to other people, because I'm vulnerable here first.

"Yeah, he's seen me through a lot!" This quote from Donald describes the next way in which clients discussed being helped by their therapists. A number of clients related how their therapists have been there for them through difficult life experiences. Jean commented on this stating, "She's seen me through some of the biggest, most painful things in my life." These clients also described the relationship as a source of strength and a constant reminder of their own personal strengths as they navigated through crises and life transitions. One client spoke about his therapist seeing him through difficult life events including hospitalizations and even partial reassignment

surgery. Donald further clarified his therapist's role in seeing him through things, saying, "There was a lot of self-doubt and he's done this quite a few times consistently over the years . . . basically told me to . . . look to my strengths."

In addition to exploring strengths, a few clients mentioned other specific interventions they found helpful. These interventions ranged from concrete behavioral techniques to powerful interpretations. Donald described how his therapist's homework assignments typically played out for him. "They usually help, but not always in the way I thought they were intended to and a lot of the times it's not so much the result as the process." Logan shared his experience of hearing new interpretations of long-standing themes in his life:

> I like that he can listen to my life and give me new points of view on the same stuff that I have been thinking about for years, but it makes sense now. It's sort of like seeing my whole life for the first time. It's really a cool feeling of being, like, oh, wow! I feel these, like, little points of understanding sink in and click into place like Legos and I'm like, oh, the topography of my understanding of why do I do this has changed forever now.

Participants identified the subthemes *Building Trust*, *Understanding Worldview*, *Shared Power*, and *Positive Change* as essential aspects of their experience in the *Development of the Therapeutic Relationship*. Once the relationship was established, clients and therapists also identified certain characteristics that defined the overall experience of the relationship. The following themes of *Shared Investment* and *Emotional Connection* discuss these descriptions.

Theme 3: Shared Investment

The third overall theme to come under the *Experience of the Relationship* was *Shared Investment*. This theme reflected the importance of each person's level of investment in the therapy process. The two subthemes under *Shared Investment* are *Client Investment in the Process* and *Therapist Investment in the Process*. Both therapists and clients commented on the clients' motivation and willingness to work as a critical part of the relationship as well as one of the most important predictors of successful achievement of therapy goals. Therapists' investment in the process also came up in many interviews. Some therapists discussed things they had done to be flexible and accommodate their clients for the sake of the relationship. Several clients saw their therapist's willingness to go out of their way and occasionally bend certain rules as a sign of their investment in the process. Even small actions on the part of therapists held great meaning for clients.

Client Investment in the Process

The first subtheme to come up under the Shared Investment theme was *Client Investment in the Process*. Several therapists expressed a belief that their clients' determination to improve, in addition to their willingness to take risks and engage in the therapy process, was the most powerful determinant of change. Kara explained her view of this as, "Most people do get better, mostly because they want to. I think I'm lucky enough to sit here while they get better, but they generally get better." Some therapists noted the diligence of their clients in bringing specific questions and goals to therapy, and practicing new ways of being. Bruce described his client's habit of coming to session

with a notebook containing questions he would like to address in therapy and suggestions/reminders for experimenting with new behaviors outside the therapy relationship. In reflecting on her client, Dinah simply said, "He will do stuff." She explained, "He's made enormous behavioral changes this year – that have really helped his life. And I'm not of course the only factor in that; I honestly think he's made excellent progress, and that it's the result of years of being honest with himself." She continued, "He's letting it unfold little by little, and I really honor that process. And I think that's the thing that's helped him the most, and he's really worked through that for a long time, starting long before me. And it will continue long after I'm not in his life, I believe."

Each therapist described a real appreciation and respect for their clients' ability to be vulnerable, tolerate discomfort, and engage in the difficult work of therapy. When commenting on her client's willingness to invest, Selina said, "He's insightful and motivated . . . willing to share his struggles and vulnerability." She went on to say, "I just want to value that - that he's just taking those risks and I'm deeply appreciative of that." Helena acknowledged the fact that her client is "always in there working, trying, wanting to change, wanting to be a better person; and that's very rewarding in a psychotherapy relationship."

Arthur also described his appreciation of any client's willingness to take risks, stating, "I've been in plenty of therapy myself, so I know what that feels like, and it's hard." He went on to note, "I'm respectful of that, and try to acknowledge that of people, especially in the beginning . . . especially if it's something that would be typically very difficult for them." When speaking about his client in particular Arthur said:

> I would just want to emphasize . . . his openness to me, and to looking at things, at himself, and I think I feel like that's a huge part of why our relationship is good. He has placed a trust in me, and obviously I have to live up to that trust, you know. But I feel like a lot of it comes from him, in terms of just being able to show up for those things and talk about stuff that's pretty vulnerable actually. Things that are, things that you don't necessarily feel good about with yourself, with things that are pretty private, and I think I'm, I feel especially respectful of that with him . . . I feel appreciative and respectful of his ability to say, "You know, this is the stuff I need to work on, so I'm going to do it." And he didn't have to do that.
>
> "Yeah it just didn't really make sense to be doing this if I wasn't going to try."

This quote from Warren captures the clients' perception of their investment in the therapy process. Most clients acknowledged a personal responsibility for making therapy successful and creating change in their lives. These clients also expressed, as Warren said, a sincere "willingness . . . to come here, to change." There was a sense of trusting in their therapist and the therapeutic relationship as well as an expectation that they also do their part to get the most out of therapy. Clint described this as a "mutual relationship." He said, "If she's willing to call me out, I'm the one that has to be willing to let my emotion or let my opinion and thoughts out; and ultimately that's in my control. You know, I can always BS stuff with her, but it's not going to do me any good."

Henry, who admitted to being less than invested in the therapy process when he first began, said, "I think a lot of it has been on me, and I think my own personal growth [from] seeing therapy as a hoop to jump through, to seeing it as a tool to improve myself and the way I interact with the world." He went on to comment that this change in thinking about therapy had him feeling "empowered" and "feeling like I can take steps to make [my life] better and I think a big piece of it was, 'Am I willing to go there?' And if

I'm not willing to go there in therapy, I'm definitely not going to be willing to go there in my life."

Finally, with a big smile on his face Steven proudly related the following story during our interview about feedback from his therapist regarding his commitment and willingness to engage in the therapeutic process:

> When I go in there to talk to him it's like I go in and sit down and we conversate. I ask him questions about how do I get over some of these things that I keep on doing that I don't notice I'm doing . . . And so I've been going in there with questions, and he's like, "You know what?" He says, "Between me and you, you know this thing we got? You're not like a normal patient that I've had." He says, "I've got a lot of patients that are ordered to seek counseling or this and that. But you want counseling. You're seeking counseling. You want it, you want to change this. You want to be back to the person you want to be." He goes, "You're asking me questions! I'm not asking you questions, you're asking me questions and taking notes. That's good!" Because I was all, "What are you smiling about?" And he goes, "Most patients don't ask me questions and want to take notes. I'm usually the one asking the questions and taking the notes, and here you are…that's good, that's good because that means you're trying to help yourself, you know?"

Therapist Investment in the Process

Therapist Investment in the Process was the second subtheme under *Shared Investment*. Several therapists described their willingness to be flexible and accommodate clients for the sake of the relationship. This subtheme was exemplified in how therapists dealt with boundary issues and dual relationship concerns in addition to ways in which they seemed to go beyond their usual practice when clinically appropriate. Dinah commented, "When he's having trouble I try to see him every week. And he knows that I go out of my way, that I sometimes give up a lunch hour, or stay an hour after . . . and he's appreciated that, I believe." Selina explained how she is a supporter

and advocate for her local GLBT community and that her client plays an active role in this community as well. She said, "There's a balancing component to that relationship . . . in that I am very much involved in the community and he'll invite me to events that he's hosting, things like community outreach work within the GLBT community." Selina stated that she will attend her client's events in the interest of supporting him and also to better understand his life experience as a means of furthering the work they do in therapy.

Four therapists mentioned their willingness to meet with clients' partners or family members in order to strengthen the therapeutic relationship and help clients improve the other important relationships in their lives. Diana talked about meeting with her client's wife who had some initial concerns about their therapy relationship. She stated that after working with both the client and his, the wife eventually told her, "How grateful she was for everything that I'd done for them." Bruce, who works in a small, rural community, described an incident where he decided to do something different with his client that had a great impact on their relationship:

> I've not done this with any other client; but with him and because of his concerns and because we're in this community…he invited me over to his home when he had his children on the weekend, to meet his children and I went. I met him in the family environment, talked to his kids for a few minutes, talked with his then girlfriend. I had my shirt and tie on. I always have my shirt and tie on because I look so blasted young. It helps make me look a little bit more professional . . . as my way of keeping the boundaries. [I] didn't stay for dinner, although they begged me to. So I think that for him, was huge. I don't think he's ever had a physician, or a therapist – and he's had many – ever do that for him. And I really believe that . . . well, we already had a good relationship, but that cemented it for him.

Issues around payment and reimbursement were also mentioned. A few private practice therapists mentioned dropping their fee or making alternative arrangements to accommodate clients with financial difficulties. In each case, the therapist stressed

concern for the client and, as Diana phrased it, the need to "handle it therapeutically" without increasing financial stress on the client. Bruce described a situation in which insurance reimbursement is sacrificed in favor of early relationship development:

> I really want to hear them. I become very interested in their problem and their suffering. I want to know it a lot better; and it makes doing an actual assessment I can actually turn in to the insurance - that may not happen for a couple of sessions. Which, then I get bit because they're like "Oh, well, too bad, we're not paying for it." It's a risk I take because I believe it's important to develop that relationship and with him in particular.

Helena even discussed accommodating a long-term client despite some drastic changes in her practice:

> When I first started seeing [my client], I was much more of a generalized consultation liaison psychologist. But over the years what has changed is my career. And so I don't see other ongoing clients outside of my pediatric practice. Initially it was the need that she had and just how much the need was . . . I think over the years, and certainly when she came back to therapy, really for me, it was I think a willingness to stay involved in her life to help her out, to act in this consultation kind of role.

Henry, a man with a history of serious depression, and currently in the midst of enormous personal transition, shared a critical event from his therapy experience involving his therapist going out of her way to support him. He described the great personal meaning her actions had for him, demonstrating his therapist's genuine investment in him.

> On a personal note too, I made a presentation at PFLAG a couple of months ago, and I invited [my therapist] to come and just to listen, because I was proud . . . I was making a presentation that I wanted her to see. And she changed her schedule around so she could be there and just, support me. And that was the type of like, really sincere, authentic love that meant so much to me. Like, "Really?! You would change your schedule around and come to this meeting on a Monday night at 7:30 to support me? I mean, I'm your client, I'm not your friend, I'm not your . . . like, I'm one of your clients, and you would do that for me?" And it meant . . . it meant a ton to me, and I don't think I even told [her] how much it meant because I would have started crying. But that was a big deal. Yeah,

> so just her, the way she is a professional about it and at the same time how compassionate she can be. Those are really important things.

Client and therapist participants in this study described the impact of *Referral and Initial Impressions*, factors contributing to the *Development of Therapeutic Relationship*, and a sense of *Shared Investment* in the therapy process as important themes in their experience of the therapeutic relationship. Participants also identified a more personal aspect of the relationship. This connection is examined in the final theme under *Experience of the Therapeutic Relationship* in the following section.

Theme 4: Emotional Connection

The fourth major theme to emerge from the *Experience of the Relationship* was *Emotional Connection*. This was an unexpected theme that emerged from both therapist and client interviews and had to do with the sense of genuine affection and caring each member of the pairs had for one another. Clients and therapists seemed to have a real emotional connection to one another. It was expected that clients would speak well, perhaps even fondly, of their therapists. This proved to be accurate. Most clients in the study spoke quite extensively and with strong emotions about their feelings for their therapists. It was clear that the clients cared about their therapists and felt cared for as well. In the initial therapist interviews, it became evident that the therapists liked their clients as people quite a bit. All of the therapists in this study expressed some degree of caring for their clients and a sincere concern for their well-being that seemed to go beyond a strictly clinical interest in the clients' improvement in psychosocial functioning. This main theme of *Emotional Connection* yielded three subthemes: *Caring*

Relationships, *Positive Perspective*, and *Liking Who I Work With*. These subthemes are explored further from both therapist and client perspectives.

Caring Relationships

The first subtheme under *Emotional Connection* was *Caring Relationships*. The idea of the therapy relationship being a caring and emotionally intimate relationship often came up unsolicited during the interviews. Therapists frequently talked about liking their clients. Clients shared their feelings of affection for their therapists in addition to the sense that their therapists truly cared for them.

Some therapists were very direct about their feelings. Kara remarked, "I think she knows I like her and I do." Dinah commented, "I feel, I really like him…and it's true of many of my clients, but I really, really like him." Another example was Barry's comment, "This is a client that I happen to be fond of and I think we have a good relationship." This subtheme also came up in how therapists spoke about their clients, often in ways that communicated respect, honor, and gratitude. This seemed to be such a strong theme that I began to explore it more deliberately with each of the therapists. I also began to ask each therapist how important it was for them to like their clients. This is further developed in the next section.

As they described the therapeutic relationship, each therapist in the study expressed some feelings of affection or caring for their client that seemed to impact the relationship in a positive way. At the beginning or our interview, Barbara stated, "I really like him and care about him." She returned to this theme towards the end of the interview as well remarking, "I hope he's accurately sensed that I really care about

what's happening to him and I find him interesting and his dilemmas and challenges are so legitimate, his efforts to respond to them, to me, show a lot of values that I resonate with." When asked about additional factors that may have contributed to the relationship with her client, Diana reflected:

> You know, I think, I guess the other thing that has added to this relationship with the client is that I like him. I think he's a really good guy and he's really trying . . . and I hope he ends up … I'm assuming he ends up feeling that from me, that I just genuinely like him and genuinely care about him and want him to be okay and his wife to be okay and their family to be okay.

Two therapists described feeling an immediate connection with their clients. Hal remarked, "I liked him from the beginning. It wasn't like I had to develop a liking for him." Clark, whose client was transferred to him from a trainee he was supervising, stated, "I already had feelings of warmth for this person as you do when you supervise somebody . . . they never even see you, but you, supervising around a particular client, you felt a certain affinity, at least I do."

This theme was not confined to those therapists in the study who identified themselves as more humanistic or feminist in their orientation. Even those therapists who identified with a more cognitive or behavioral approach to clinical work mentioned the caring aspect of their relationships. Helena shared that from her client, a powerful piece of the relationship was "feeling like somebody cares about her consistently and that she has value in the world, has something to contribute to the world." Oliver, who described himself as a "doctrinaire devout" of a particular cognitive behavioral school of therapy, expressed his tendency to "worry" about clients whom he has not seen in some time. Dinah, who expressed great concern over her clients' high level of distress, said this:

> It's a serious issue, and that's a challenge and worries me. It would be wrenching to me if he killed himself, and such a loss of a fascinating, capable, human being on the earth . . . it's so clear to me how sad it would be if he died. And I think that my sense of that is sharpened because I like him, and I imagine other people who can ever be his friends in his life, how life-enriching that is. And I may have a little more of that in his case because I like him so much.

For clients, the theme of feeling cared for seemed to mirror the theme of caring for clients found in therapist interviews. Clients in this study communicated a clear message that having their therapists care about them was one of the most important factors in forming and strengthening the therapeutic relationship. This was evident in the following comment by Jean: "I think something that I need as a client is somebody who understands me, who cares about me; and I know she cares deeply about me."

Most clients in the study reported a belief that their therapists genuinely cared for them and seemed invested in their well-being. Donald simply expressed this with the language he used describing how his therapist was "looking after me." Henry said, "I could tell that she was sincerely upset and empathetic about what I was going through." He explained, "It wasn't just 'I'm a therapist, I'm supposed to care.' It was, 'I really genuinely care about you.'" Clint remarked, "I understand that I'm a client and everything, but she actually shows interest, I don't know how to exactly explain it, but, just really seems concerned, and just really wants to help. And it's just not going through the motions."

Some clients described ways in which therapists communicated caring for them both in and out of therapy sessions. Speaking about his therapist, Logan stated, "He'll say things like, 'I just don't think that this is true of you,' when I'll present some negative aspect. Or he'll say, 'I really enjoy working with you.'" Logan went on to describe how

his therapist reacted when he expressed how meaningful the therapy relationship has been to him, "And he said, 'It means a lot to me, too.' So the fact that I think he has a good time, too, is important. That he doesn't look down at his schedule and see me and go, 'Oh, shit, what are we going to talk about?'" Henry related how his therapist sent text messages to him during a particularly difficult time, "And that spoke volumes to me just that she would send a text message to me saying, 'Hey, how are you? I'm thinking about you.' That type of sincerity I don't think you get with every therapist."

Steven, a man with severe PTSD and a long history of unsatisfying experiences with mental health providers, shared a critical event that occurred for him in his relationship with his therapist. He became quite emotional describing this brief interaction with his therapist that seemed to mean everything to him and demonstrate true caring:

> It like calmed me down right away, just hearing his voice and talking to him for a second. When my uncle died, and I called him up on the phone and he answered to me right away. That really made me feel good inside - that he was there for me. Because I didn't know who to call, I tried to call a friend, and everybody was sleeping . . . I called him, and I was kind of upset and I was crying and stuff, and he answered to me. You know? I *called* him and he *answered* to me. He says, "What's the matter, are you ok? Where are you at, are you ok?" And I'm like, "I'm fine right now, I just need somebody to talk to. My uncle just died and I don't know what to feel or what to do. I just want to talk to somebody right now." And he talked to me for a little bit, he didn't need to talk to me for very long, and he calmed me down and I just said, "Sorry for calling you so late, and thanks for answering to me." Just him answering to me and talking to me for a minute, that meant everything to me, you know? Just that little conversation that he had with me, we didn't really even have to say much. It was just knowing that he was there for me when I needed him.

Clients also reported finding comfort and meaning in feeling that their therapists were constant advocates for them. Donald referred to his therapist as "my psychological advocate." Henry mentioned the importance of his therapist doing social justice work in

the community, but also being "my ally specifically." Jean captured the essence of this experience by saying, "You know, she just always was on my side . . . she would tell me when she thought I was wrong, but I knew that she was always on my side."

Natasha, a young woman with a trauma history, struggling with intense feelings of guilt and shame described a critical therapy event that she experienced related to feeling cared for. She related this incident in therapy to demonstrate her therapist's love and compassion:

> And what great, great love that [my therapist] has shown me, like he gave me hugs all the time. We end our sessions with hugs, because, honestly, I do have my roommates to go hug, but coming from a father figure, or coming from a male figure, who can actually give me a hug means so much more to me. Of course I'm not attracted to him, but at the same time, with those emotions going down my face, deep inside of me, I can't go on unless I have a hug. That's where my assurance comes in, and that's where I know that I'm going to be feeling okay as soon as that can be let out right. But my emotions, it just has to be let out every single time . . . that's how it came to be, where I think I did ask him, "Um, I'm going to be getting more sessions with you, I need to have a hug. Do you mind if I can get them from you all the time?" And he's just like, "Of course you can. You don't need to ask me, so just always come in here for a hug, whenever you need." So, it's been really good for me.

An interesting theme that emerged in several of the client interviews was a tendency for clients to describe and/or compare the relationship with their therapist to that of friends or family members. This was often expressed as the clients were speaking about the emotional closeness and level of intimacy they felt in the relationship. These responses involved comparing the therapy relationship to family relationships, close friendships and teacher/mentor relationships. Two of the clients discussed their therapists in terms of multiple categories. In addition to describing the closeness of the relationships, a common thread that seemed to run through these comparisons was perception of the therapist in the dual role of listener and advice-giver.

Four clients compared the relationships with their therapists to relationships with close family members. Some of these comparisons seemed to be based on the types of relationships the clients wished they had with family members rather than on the real relationships they had in their lives. Describing her therapist, Natasha said, "He's more of like, my Dad. My Dad and I have a good relationship, don't get me wrong, but like the thing is I'm not able to tell [my dad] things . . . I'm not that open." Janet compared her therapist to a more idealized version of her mother:

> I could never talk to my mom about those things, so for me, it's kind of like having that kind of a person that I can come to and . . . she's not old enough to be my mom, but she's in that position where she's been through those things and she gets what those situations are like, and my mom wasn't in a place where she could help me. She wasn't mentally stable enough . . . It was always a difficult situation, so to have somebody who's willing to share their experience and advice with me is invaluable to me, because I don't really have that to draw from anywhere else.

Pedro commented on the trust he placed in his therapist and remarked, "That's the way I feel when I talk to my parents or the way I feel when I talk to . . . my best friend's mom . . . whatever they say, they will say it because they want the best for you, you know? And that's pretty much how I feel now." Donald had a different perspective on his therapist, stating, "He's kind of like a big brother." He went on to say, "That's the way I kind of see him is sort of a big brother figure. He's a little bit older than me as well. We're about the same stage of career. He's a little bit ahead . . . and so, in that sense I kind of look to him for brotherly advice."

Five clients described the relationships with their therapists in terms of a close friendship. Some even commented that they imagined themselves becoming friends with their therapist had they met in different circumstances. Janet said, "I've told her before, I feel like she's a good friend who gives me good advice that I get to come and talk to once

a week." She further speculated that "if I had met her outside of here, she's somebody I would choose as a friend. She's that kind of a person that I just would hang out with … and I appreciate that, that it's not *so* professional." These clients also stressed the trust, as well as the warm, friendly nature of the conversations they experienced in therapy. Pedro was quick to express an awareness of the difference between a therapy relationship and a friendship. He emphasized that his therapist maintained "professional" boundaries while achieving a good "balance" of a trusting friend and a professional.

This comparison to a friendship was most apparent with Jean and Steven. Each talked about their therapist with a deep appreciation and sincerity that reflected the critical role these relationships have played in their lives. Jean explained it like this:

> It's not just a friendship … I take her to dinner, she never charges me, it's not really what you call a professional relationship. It is more of a friendship except it's very one-sided. She listens and gives me wonderful advice . . . I bought her a necklace for Christmas that said something about "You walked in front of me when I needed to follow, and walked beside me when I needed a friend." That's how I see her. And the other thing that I painted for her…is the quote that says, "A friend is someone who knows the song in your heart and can sing it back to you when you have forgotten the words." And I feel like she does that for me too. I feel like she really knows.

Steven described his therapy relationship as follows:

> We can talk about anything, you know…almost like a best friend . . . Because the relationship that me and [my therapist] have together is like, of course you know it's confidential. When I go in there, like . . . he texts me because he knows I'm forgetful, and I have a hard time remembering. And so he texts me, "Hey, how's it going? You going to see me today?" And it makes me happy that he texts me, to remind me. It's almost like talking to a friend. I feel really good about it, and I'm really comfortable with him, and I look at him as a good friend. You know, someone that I can confide in, somebody that I know when I talk to it's confidential, and nobody else can ever know. And our friendship is like a friendship that nobody else can have.

It is interesting to note that both Jean's and Steven's therapists were very much aware of this dynamic. Both therapists spoke extensively about how their clients continued to want the relationship to develop into more of a friendship. These therapists also stressed their own ongoing efforts to maintain professional boundaries and be flexible enough to provide care and support while staying mindful of what is best for their clients.

Anthony considered whether his relationship with his therapist might change after they ended their therapy relationship. He said, "I could see being good friends with [my therapist] outside the office with my wife and I having her over for dinner and stuff like that . . . but I've kind of wondered . . . when I stop therapy, how will our friendship be?" He went on to say, "I think we'll have a good friendship, but I guess there's that uncomfortableness of not knowing how a therapist would feel about that."

Interestingly, Steven, who emphasized the close friendship in his relationship to his therapist, also reflected on the one-sided nature of the therapy relationship:

> I don't ask him what he does for his social activities. I don't get into how is your family life . . . stuff like that. I talk about my family life and about my kids, and he knows everything I'm going through and stuff. I don't get into um . . . with him, what do you do? Because he's my therapist and that's maybe private to him, maybe not, who knows? So I just . . . If he wants to tell me, he'll tell me. I just leave our relationship as it is.

His comments seem to indicate a respect for his therapist's privacy and perhaps a reluctance to do anything that might jeopardize this important relationship in his life.

Two clients mentioned also seeing their therapist in the role of teacher or mentor. Donald stated, "And so there's a very small amount of mentoring, professional mentoring involved . . . Although I'm not sure he would see it that way." During his interview, Steven brought out a notebook he brings to therapy sessions that was filled with notes he

had taken. He explained, "I go in there like I'm going in there to learn, you know? And he's my teacher . . . I guess you can explain it like that . . . I'm the student, and he's my teacher."

The sense of caring for and being cared for was a powerful part of the therapy experience for both therapists and clients in this study. In the context of Caring Relationships, clients and therapists described the ways in which challenges were perceived and addressed. The next subtheme deals with how challenges were managed in therapy.

Positive Perspective

A second subtheme to come up from *Emotional Connection* was *Positive Perspective*. This subtheme seemed related to the emotional connection between therapists and clients in terms of the manner in which relationship challenges were described. Some therapists seemed to separate their clients from any challenges encountered. Some clients adamantly denied any challenges or conflicts came up in the course of therapy, but clearly mentioned challenges in another part of the interview. There appeared to be a tendency to look at the relationship through a more positive lens than was perhaps accurate.

Three of the therapists interviewed reported some difficulties or concerns about the relationships with their clients. These concerns ranged from a client's tendency to push boundaries to not feeling as close a rapport with a client as they would have liked. In each case, however, therapists still expressed caring feelings for their clients and attributed the perceived relationship problems to the clients' diagnoses rather than the

person. Barbara commented on a lack of the typical closeness she feels in therapy relationships with her client and pointed to the client's restricted range of affect due to depression as the likely cause. Oliver remarked on his inability to take on the "avuncular" role he most often assumes in therapy with his client and attributed the client's high level of anxiety for this. In each case, there seemed to be a real pattern of separating the person who is their client from the diagnosis. It should be noted that these therapists did not communicate any sense of blame or criticism toward their clients. On the contrary, they took responsibility for navigating through the clinical symptoms and overcoming the challenges to their relationships. Even in describing challenges, underlying feelings of respect and caring for their clients were present.

Seven of the clients interviewed reported having no challenges or conflicts in their therapy relationships when asked. Natasha, who identified as being of Pacific Islander descent, stated, "I can't even think of one . . . there hasn't been any rough spots or anything." However, she also mentioned feeling as though she needed to act and speak in a more "American" manner rather than the way she typically presents herself with members of her same ethnic group, out of respect for her therapist. Clint said, "The biggest challenges are on my own, like remembering the exercises and things that she's given me, or remembering what we talked about the week before." It should be noted that none of the clients in this study verbalized any major complaints about their therapist or expressed dissatisfaction with their experience in therapy. Most of these clients seemed reluctant to mention anything that could be perceived as negative in relation to their therapist. A similar pattern came out when first discussing differences within the therapy relationship.

Another unique, but important, point that came up with a small number of clients had to do with taking on a more passive role in the therapy relationship. Although each of these clients reported experiencing positive results from therapy, some comments suggested that they may avoid disagreeing or expressing conflicting views with their therapists. Natasha, who previously reported no challenges, described her process when her therapist says something with which she may not agree.

> I try to see like, "Where'd he get that point from?" I try to understand . . . 'Okay, I'm not taking it personal, and I'm not taking it lightly either, but, that's what he meant.' There was never anything like a disagreement or [an incident where] I walked out being mad. I'm just like, "Oh, I can see where he came up with that. But that's a good reason why he said that," You know? I was more humble instead of like, "Well, dude, you should've helped me more," [or] like "I disagree with you."

Jean recalled a past incident when she was quite angry with her therapist, but stated, "She's been such a help, I think I just sucked it up." Warren also described some occasions in therapy where "I kind of wanted to fight what he was saying, but I knew that he was right or he had a point but it was just something difficult for me to grasp, so it was a little harder to agree, even though I did." These comments seem to reflect reluctance on the part of the clients to disagree or challenge their therapists in the context of the relationship. This may be an attempt to protect the relationship from any disruption. It may also represent a fear of abandonment or rejection on the part of clients. This reluctance may also illustrate the underlying power imbalance between therapist and client, which can sometimes be exacerbated by cultural differences.

One client, Warren, reported some struggle in feeling understood by his therapist. He noted a lack of personal connection stating, "It just kind of seemed like he's been doing this for a while so he knew the things to say . . . almost like it was kind of

rehearsed." When asked what he might prefer in the relationship, Warren explained he would rather not feel like "I was just the next kid coming in or whatever. Just like part of his daily work, but more of a personal like, 'Hey I'm here to help you, we're going to get through this."

Liking Who I Work With

The last subtheme to emerge from *Emotional Connection* was *Liking Who I Work With*. When asked how important it was for them to like their clients, therapists replied in a number of different ways. A typical immediate response involved commenting on how interesting a question it was and then stating that they had spent considerable time thinking about it. Ten of the therapists interviewed stated they believed it was at least somewhat important to like their clients, though not necessary. All of the therapists stressed the importance of being able to connect with clients in order to do have any success in therapy. Two therapists reported being explicitly told by professors in their graduate training that it was not important to like their clients. One even mentioned being "dinged" by a supervisor on this issue. Oliver explained that, for him, it is not about liking the person, but more about "how they behave and what they believe in and what they value."

In general, therapists reported they could still do good work without necessarily liking their clients, but most agreed that liking their clients contributed to heightened job satisfaction, greater investment in the therapy process, and a stronger relationship. Speaking about how liking her clients increased job satisfaction, Diana said, "It makes it easier for me. It's more distracting to me when I don't like a client and it's more onerous

to me to work with a client when I don't like them." On a similar note, Selina stated, "It makes my time spent with them more enjoyable." She also went on to say, "The reality of it is that the majority of times I really like my clients." Donna reflected on a past client (not included in this study) who caused her to rethink this issue and said, "Now I'm kind of conflicted. I don't know that I really liked that client and yet we did some really good work."

Some therapists linked liking their clients to being more effective in session and more invested in the overall process of therapy. Hal stated that, when he likes his clients, "I think I'm more invested in their story. I remember things better and track and bridge things from session to session. I mean, if I don't like them, I think I'm less invested if I'm really honest with myself." He went on to consider the implications of having no strong feelings for a client:

> I guess if I'm neutral and I don't dislike them, but I don't like them, that may be the biggest issue, because I think some of the clients that I dislike, I may also be pretty heavy into thinking about them . . . It's not like I dislike my clients, but I'll bet with some of them who are more challenging in different ways or just pull out some counter-transference for me or others, I'm sure that nonverbally and behaviorally I'm showing some signs that I'm less invested.

Clark explained his thoughts about his effectiveness with clients he likes:

> Well, I used to have a professor that said "It's not, it's not important that you like 'em, you can still help 'em without liking them." And I believe he was right, but that's not so much my personality. I really want to like the people I work with. I want to feel positively toward them and I work to do that. So it makes therapy, at one time a lot more engaging and interesting, and at the same time, uh, it helps me to feel a greater investment, which is nice. If I genuinely don't like a person, I don't think I'm personally as effective. I think I can help a person, I think I've helped some people I don't like, but probably not as effectively.

Several therapists framed this issue in terms of being able to connect to clients effectively. Barry said, "I think it's very important that we find genuine ways to connect with clients and some people, therefore some clients are easier to connect to than others and frankly easier to like." Barbara reflected on her experience and put it this way:

> I would like to like every client. I know that I do not like every client . . . I recognize that I have limits, probably most of us, or all of us have limits, on who we can like and some clients are here because they're having trouble getting along with everybody. But I guess I really almost feel like I have to find something to connect to, and with some clients it's super easy to find them likeable, and with some, it's uh . . . I almost have to look for their pain and when I get a sense of what their pain is, then I can sort of relate to that in a way and respond to that.

For Helena, it was more about the working relationship. "Do I feel like I can maintain a positive and healthy working relationship with this person?" She explained, "There certainly are some people that I don't particularly care for, but who [I] work pretty well with. We understand each other . . . we respect each other's opinions."

Similarly, Arthur said, "I'm trying to think of the people I've had the most trouble liking – and it's hard for me to say that I dislike them . . . they're the people who are not open to the process, like they're not really wanting to do things." He went on to clarify:

> I haven't had many clients that I don't like. And I think part of that is that …it's not my job to like them, but it's my job to find a person's strengths, and that's what I see as part of my job, is to find a person's strengths, and to kind of go with those, and to help people find understanding . . . self-understanding and forgiveness about those parts that are negative about themselves, or that are perceived as negative about themselves. And so I think I tend to really focus on the things that I really do like about people.

Finally, Bruce was somewhat surprised by the question and stated he had not considered "whether I like my clients, and whether that's important for me to like my clients." He attributed the development of a positive therapeutic relationship with his

clients to his interest in their story and their treatment of others. He explained his thinking on it as follows:

> In almost all instances, when I have been – and it's most – when I've been fascinated by my client's story…by their history, by their problems, and their difficulties and suffering…the therapeutic alliance seems to come right along for the ride . . . The instances where I've felt absolutely repulsed by a particular client and their way of being in the world, you know, they didn't come back . . . What's difficult sometimes is when I see them in the moment, hurting somebody else by their behavior…I have a hard time getting past that.

Part I of this chapter addressed the first main research question that guided this study. This question sought to describe clients' and therapists' experiences of the therapeutic relationship. The four major subthemes clients and therapists identified as essential to their experience of the relationship *Referral and Initial Impressions*, *Development of Therapeutic Relationship*, *Shared Investment*, and *Emotional Connection*. These themes seemed to work together and built upon one another to create a unique, dynamic relationship for each therapy pair.

Part II of this chapter addresses the second research question regarding participants' experience of differences in the therapeutic relationship. Each therapy pair included in the study contained some meaningful difference between client and therapist as identified by members of the therapy pair. These differences and the impacts they had on clients and therapists in the same therapeutic relationship are discussed in the second half of Chapter 3 (see Table 4).

Part II: Experience of Differences

The second half of each interview focused on participants' experience of cross-cultural differences in the therapy relationship. Clients and therapists were asked to

identify any differences they perceived in the relationship with the following question: "In what meaningful ways do you see yourself as different from your therapist/client?" The question was purposely vague and open-ended in order to elicit participants' awareness and interpretation of any differences in the relationship they viewed as meaningful. They were also asked to describe how the perceived differences impacted the therapy relationship, how the differences were addressed in the relationship, and how much of a role these differences played in their own personal identity formation. In analyzing the interview data three main themes emerged from the *Experience of Differences*. They were *Dimensions of Identity*, *Building on Common Ground*, and *Power and Responsibility*.

Table 4: Outline of Results Part II

- *Part II-Experience of Differences*
  - *Theme 1-Dimensions of Identity*
    - Race, Ethnicity, and Culture
    - Gender and Gender Identity
    - Religion
    - Age and Experience
    - Socioeconomic Status
    - Sexual Orientation
    - Relationship Status and Relationship Orientation
    - Life Experience and Trauma
    - Personality Style
    - Appearance
    - Language
  - *Theme 2-Differences as Enhancing the Relationship*
  - *Theme 3-Building on Common Ground*
  - *Theme 4-Power and Responsibility*

Theme 1: Dimensions of Identity

Rather than using the term "differences" to emphasize the ways in which clients and therapists differ and are set apart from one another, one therapist in the study, Selina, chose to use the phrase "dimensions of identity." As I analyzed the interview data and common themes emerged, this phrase seemed to be a more accurate descriptor for the phenomena being studied. Both clients and therapists appeared to recognize the meaningful ways in which their identities differed and converged on various levels. There was an acknowledgement of the importance of both differences and similarities within the therapy relationship, as well as the richness of each individual's identity. For the most part, study participants were able to talk about these issues with respect, honoring one another as complex individuals with a variety of group affiliations. They did not cast their therapy partners as a different *other,* completely removed from their own experience. Although the phrase *dimensions of identity* seems to capture participants' experience of one another in a more accurate way than simply identifying differences, the term differences is used throughout this section as an easier way of referring to the phenomenon and for purposes of flow.

A number of cross-cultural differences or dimensions of identity were identified by both clients and therapists, with significant overlap. In general, therapists tended to identify more dimensions of identity in the relationship than clients. As a group, clients identified 12 differences within the relationship. Therapists as a group identified 19 separate differences between themselves and their clients. These different dimensions of identity are identified and explored in detail below. There were three main subthemes that emerged from the discussion of dimensions of identity in the therapy relationship

across all participant interviews: *Awareness*, *Impact on Personal Identity*, and *Impact on Relationship*.

Overall, therapists seemed to assign more meaning to the differences in the relationship, with the exception of age and experience. On the whole, therapists also demonstrated more sensitivity to the ways in which differences might impact the therapy relationship. Clients in this study seemed more likely to minimize or overlook differences between themselves and their therapists, even obvious visible differences such as race and gender. Whereas therapists were more likely to identify possible challenges that might arise as a result of cross-cultural differences in the relationship, clients were more likely to discuss differences as positive or helpful aspects of the relationship. One strong theme that emerged in both client and therapist interviews was the overwhelming preference to identify and discuss similarities in the relationship rather than differences. Despite the frequent mention and explanation of differences in the recruitment materials, the informed consent, as well as the interview questions, the majority of participants expressed a clear desire to focus on things they perceived to have in common with their partners in the therapy relationship. They did not typically state this directly, but instead continuously directed the conversation away from differences.

However, clients and therapists still identified a wide range of differences in their therapy relationships. These represented visible differences such as gender, and nonvisible differences such as sexual orientation. Some differences represented frequently used group demographic categories such as race, while others represented more individual variation such as personality style. As mentioned above, therapists in this study typically identified a larger number of differences (19) than did clients (10).

The differences in identity within the therapy relationship mentioned by therapists included: gender, race/ethnicity, religion, socioeconomic status, age, sexual orientation, life experience, trauma history, personality, gender identity, culture, appearance, family history, marital status, relationship orientation, education/employment, physical deformity, lifestyle, and life experience. The differences in identity within the therapy relationship mentioned by clients were: religion/spirituality, gender, gender identity, race/ethnicity, age/experience, socioeconomic status, sexual orientation, personality style, relationship status, and appearance. These areas of difference mentioned by participants were combined under 11 common subthemes: Race, Ethnicity, and Culture, Gender and Gender Identity, Religion, Age and Experience, Socioeconomic Status, Sexual Orientation, Relationship Status and Relationship Orientation, Life Experience and Trauma, Personality Style, Appearance, and Language. These subthemes are discussed in detail below.

Race, Ethnicity, and Culture

Although race and ethnicity are two separate constructs, participants in this study tended to use the terms interchangeably. Some clients and therapists also used the broader term culture when speaking specifically about race or ethnicity. During the analysis of the interview data it became apparent that the interchangeable use of these terms and the variety of individual participants' interpretations of them, it would be impossible to adequately separate race and ethnicity into two distinct subthemes and still maintain the participants' original meaning. Cross and Cross (2008) addressed this difficulty distinguishing race, ethnicity, and culture stating, "the discourses on racial,

ethnic, and cultural identity overlap at the level of the lived experience to the point that there is little reason to associate each construct with a distinct identity constellation" (p. 156). They chose, instead of three different categories, to use the abbreviation REC to denote race and/or ethnicity and/or culture (Cross & Cross, 2008). Therefore in this section, race, ethnicity, and culture are addressed together in a single broad subtheme and are at times referred to as REC.

Awareness of Race, Ethnicity, and Culture

Seven of the 13 client/therapist pairs in this study endorsed a difference in REC. Out of these seven pairs, two had therapists of color and White clients, and five had White therapists with clients of color. In all seven racially/ethnically diverse pairs the therapists initially identified REC when asked about differences. However, only three of the clients in these pairs initially identified REC as a difference when asked. I had to ask the other four clients directly about racial/ethnic differences in the therapy relationship to initiate conversation around race. All four of the clients who did not initially indicate REC as a difference were people of color. The two White clients in racially diverse pairs mentioned race without prompting and one of the clients of color initiated discussion around race without prompting. It should be noted that the one client of color that brought up race on his own was a graduate student studying critical race theory.

Impact of Race, Ethnicity, Culture on Personal Identity

Four of the five clients of color in this study reported their REC as a primary aspect of their identity. Even those who did not initially mention race or ethnicity as a

difference in the therapy relationship acknowledged the importance of race/ethnicity in their daily lives. Most of these clients commented on the experience of being a person of color living in a majority White community and the difficulties of navigating between two or more cultures. Natasha, who identified as Samoan and Filipino, talked about the pressure to acculturate, stating, "I grew up with more Samoans, and that's the way I act most of the time if I'm not around with all the Americans and stuff." Pedro also mentioned the difficulty of being immersed in a culture different from his own: "I've been living here for a while and I care about this country and the people; but, you know, home is not here. So, I think the way I am, that comes probably 90% because of my experience back home and my friends and family." Donald, a client of color who grew up outside of the United States in two different cultures, referred to a sense of "cultural homelessness" a term introduced to him by his therapist. He talked about not feeling like he fit in anywhere stating, "So that puts me nowhere in so far as I don't really identify with any one group. I don't really belong to any one group and at the same time I kind of belong to several different groups. But I probably have a completely different world view."

Two therapists in this study identified as people of color and both were in therapy relationships with White clients. These therapists of color reported their race/ethnicity as being an integral part of their identities. Selina, a Latina therapist, remarked on the personal importance of having a strong affiliation to her culture saying, "It's my heritage. It's a huge part of who I am, and also something that I can't be in the closet about, even if I wanted to. You know, it's sort of like really blatant." She also discussed how

race/ethnicity is similar to and different from other dimensions of identity in terms of what she saw as different levels of privilege attached to them:

> Because I work so much with the GLBT population, I've thought a lot about ways in which [race/ethnicity] is a privilege and ways in which it is an under privilege. You know, because in some ways I feel like, even though some people may react to me because of the way I look, you know, they will. People make assumptions about where I'm from just by the way I look, right? And I can't do anything about that. I can't change it, it's out there, you know? But then many times I think about that in some ways of being a privilege because I think that I don't ever have to come out of the closet . . . and so in some ways it's like it's hard at first if people have any negative reactions but then the work is kind of done for me. And so I kind of have a lot of compassion and empathy for people that might pass in some way as main stream, but then feel like they have to come out and say, "I am different in this way. And it's important that you recognize that we're different in this way." So, it's just interesting for me to see that one dimension of your identity can be both, I don't know, like a privilege and an under privilege. A lot of my friends have commented about, "Oh, you always dress really nice." And you know what? Part of me is like, "If I didn't, I may not be as credible." People have followed me around in the store, and so I know what that is like. And so there's definitely that under privileged piece of it. But, you know, I think that I've been able to look at different sides of it.

Two clients of color seemed to express a strong affiliation with the dominant White majority culture in their communities and minimize the value of their own racial/ethnic cultures. These two clients stressed the need to either overlook race, as in Steven's case, or acculturate and adapt to "the American way," as Natasha put it. She mentioned having to step in with other people of color in her community to explain why they should also try to acculturate saying, "This is how we do it. And let's not live back in your island life because you guys are away from there now."

Two other clients of color, Roberto and Donald, expressed a more integrated racial identity and an awareness of racism in the broader culture. These clients mentioned a strong affiliation with their own racial/ethnic groups while acknowledging

both positive and negative aspects of the White majority culture in their community as well. Of note is that both of these clients also have advanced degrees and work in higher education. Roberto stated, "I have a firm belief that people of color are born with this prime to race. They are primed to understand the inner workings of race . . . for me personally, I have always understood that race was an integral component of my life since I was in my teens." Both of these clients talked about personal experiences of racism in their lives and the strategies they have used to navigate the dominant culture while retaining their own sense of racial identity. In speaking of his experience with racism in the workplace, Donald said, "It came up most in context of when I would have to deal with upper administration. It's also true when I deal with students." He went on to say,

> If you're ethnic, there's a subtle resentment towards you no matter what. But you see it, it's there, and you get a little dose of it every day, and they're not conscious of it . . . most people don't even really mean anything by it, they're not even aware that they are being [racist], that they are making a distinction at all.

Five of the therapists in racially/ethnically diverse therapy pairs were White. All of these White therapists discussed their personal understanding of their own whiteness as a significant piece of their identities. One therapist, Barbara, commented on growing up in a fairly homogeneous community, lacking in racial diversity, but developing an interest in multicultural issues after "encountering a world that is full of diversity." She went on to say that, when meeting with clients who are not "White, European-American, LDS, it probably is on my radar and I kind of like having to be challenged about that and thinking what are my blind spots and what am I assuming that's universal that isn't?"

Each talked about the privilege that comes from being White in the United States and the personal work they had done around multicultural awareness in general.

When speaking about the privilege he experiences and its meaning for him as a White man, Clark simply stated, "It means I haven't had to put up with a lot of shit!" He continued to explain saying, "Thankfully I've had some real fine instructors and friends and others who've helped me understand, to a certain extent, what it's like to be an ethnic minority in this country or be any type of minority in this country." Finally, Clark shared that he was grateful for what he had, but also felt "an obligation and responsibility that is pretty important as a person of privilege to help other persons in my position to maybe look at things a little bit differently."

Both of the two White clients with therapists of color, Clint and Henry, mentioned race as a difference in the relationship without prompting. Neither of these clients discussed race as an important part of their own identities; however, it seemed clear that Henry had done some personal work around issues of unearned privilege that comes from being White. He acknowledged an awareness that his therapist's experience as a person of color was different from his own and also expressed some empathy regarding having a minority status and experiencing oppression based on his sexual orientation. Henry also studied issues of culture, privilege, and oppression in his college major and was quite active in social justice issues. Clint, who reported having some education around the politics of race/ethnicity in the U.S., shared his personal thoughts about REC stating, "I'm pretty much indifferent on it. I don't see it as positive, negative, anything." He went on to say:

> I try not to worry about things like that or really even take them into consideration. I just live my life and if people like me, they like me, if

> they don't…I'll find out what's going on – what I'm doing, what I'm not doing, what I can do better to build that relationship and strengthen it in that aspect.

Impact of Race, Ethnicity, and Culture on the Therapy Relationship

Initially, when asked what impact differences in race or ethnicity had in therapy, four of the five clients of color with White therapists reported that REC played little or no part in the therapy relationship. These clients seemed to want to minimize any impact racial/ethnic/cultural differences had for them. As the conversation progressed, however, three of these four clients mentioned some concerns or adjustments in their own behavior based on racial/ethnic/cultural differences in the therapy dyad. Pedro, who at first reported "I don't feel [race/ethnicity] has impacted it," went on to suggest that his therapist may have difficulty understanding his cultural perspective and might assess his situation based on what is normal for her culture rather than from his cultural context. After saying race/ethnicity played no role in her therapy relationship, Natasha described how she has "on and off switches" regarding whether she speaks and acts like a member of her ethnic/cultural group or more "American." She remarked that she adjusts her behavior when meeting with her therapist, because "I want to make him feel comfortable."

Steven, who identified as multiracial, stated that REC had no impact on his therapy relationship. He said, "That's why I like him so much, because I don't feel like I'm being judged. I don't feel like he looks at me like I'm a different person than him, or vice versa." Steven seemed to imply that calling attention to differences between him and his therapist would be judgmental or rude as he went on to say, "I don't try to look at

him like, ‘You’re White, I’m Mexican.’ You know? I’m not just Mexican, my grandfather’s Jewish, my grandmother’s Spanish and Apache, my dad is Mexican. I’m a Heinz [57 sauce]. You know what I mean? Who am I to judge someone?”

Donald, another client of color, reported that he and his White therapist spoke quite extensively about multicultural differences between them and experiences of racism in his life. He noted his therapist’s knowledge and skill in addressing issues of culture and ethnicity but stated, “The cultural and ethnic differences, it just hasn’t been a big issue for me. I mean, the anxiety is, just has been the dominant, the driving force [in therapy].” For Donald, his presenting issue seemed more relevant in the context of the therapy relationship than any cultural differences.

The last client of color, Roberto, endorsed REC as a very prominent issue in his life and throughout his therapy relationship. He reported that at the start of his relationship with his therapist, he was “very cautious.” He stated that he was so apprehensive that he did some research on his therapist, “I was like, ‘I want to know who this cat is before I get involved with this guy.’” Roberto continued, “Especially being that he was White, and I’m not. But . . . I would say that the relationship really developed into, for me anyways, in a very healthy patient/therapist way, where I felt very open. I felt comfortable.” He went on to say that the dynamics around REC and how these issues played out in his life was something he and his therapist talked about frequently. Roberto mentioned that his therapist’s willingness to directly address REC at the start, as well as his familiarity with Roberto’s research area of critical race theory, contributed a great deal to strengthening their relationship. “So that made it easy for me

to talk about some of my concerns, or some of my issues that I was dealing with because I was able to put it on the table, and him being able to analyze it through that lens."

The two White clients in racially diverse therapy pairs each saw this difference from a unique perspective. One of these clients, Henry, talked about his therapist's racial minority status as an important factor in her ability to empathize with his own experience as a sexual minority. He explained:

> I think the differences of being White and being a native English speaker versus her being a person of color and maybe not a native English speaker are pretty different. So, more than anything I think with that difference comes the respect for . . . hopefully for each other's journeys. I know that I have deep respect for [her] journey, and an understanding that she'll, that she has a level of awareness and sensitivity to my journey around gender too.

Clint acknowledged the difference being present, but discounted any impact on the relationship. He could not recall any discussion around REC differences with his therapist and stated, "The way I see it is we're both just two human beings and one's trying to help the other."

Four of the five White therapists with clients of color reported discussing REC directly with their clients. Each of these four therapists talked quite a bit about their attempts to remain mindful of this difference in the therapy relationship and make it explicit. They also mentioned trying to integrate REC into conceptualizations of their clients' issues. Referring to his client, Clark stated, "I'm quite sure she appreciated that I'd ask her about her cultural background." He mentioned that they would often discuss his client's relationships stating, "I would ask her, 'So what does that mean culturally?' . . . she was able to explore a lot of that and I think that was pretty useful in forming our relationship." Barry explained that he typically tries to address differences with clients

when he first meets with them. He said, "I like to find a way, at some point, in that first hour, to open that door, and to do at least some disclosure about my own identities and some acknowledgement of the client's identities." He went on to say, "Sometimes it feels like it's up to the client's lead a bit. I always feel like I have the prerogative, I guess, as the therapist, to come back to those issues if I think they're clinically important. And with some clients I probably do that more than with others."

Some therapists indicated that conversations dealing with REC involved attempts to raise their clients' awareness. Barry recalled how discussions around this difference progressed and changed with his client over the course of their relationship:

> It seems like in the earlier part of our relationship I was the one to instigate the conversations about race and ethnicity and cultural expectations and even stereotypes. We talked about the model minority myth, and I would instigate those conversations. And, you know, the client was happy enough to go along, but this was not his instigation. And it felt like we turned a corner when, after a few years, when he would initiate those topics. And it seemed that he was paying more attention to that, seeing how some of these dynamics were playing out in his life.

Some indicated that their clients did not seem interested in discussing this difference and their attempts to address REC seemed to go nowhere. Interestingly, these individuals were also the clients of color who seemed reluctant to mention REC as a difference during my interviews.

Hal, a White therapist working with a client of color, discussed exploring the impact of REC quite a bit in their relationship. Hal talked about being mindful of where his client was in terms of racial identity development, and wanting to create an environment where they could freely discuss issues of racism and oppression in his client's life. He mentioned the importance of his own background and training in multicultural issues and his familiarity with critical race theory. He also said he and his

client spoke about how their differences played out in the therapy relationship and outside the therapy office. Hal recalled discussing his client's experiences in academia and "microaggressions and microinvalidations that have happened between him and faculty, and we did some reality testing around that and it seemed like it very much wasn't just shit he was making up, it was . . . you know, I don't get that treatment."

The other White therapist working with a client of color, Bruce, stated that REC had not come up in the relationship with his client. He discussed his awareness of issues around race, privilege, and multicultural differences. He also expressed a willingness to address those issues in therapy, but stated that his client was "pretty well acculturated" and they had yet to come up. "It's certainly not been addressed; it's one of those things that maybe because I'm of the dominant culture – and so 'It's not an issue for me, why would it be an issue for you?'" This therapist's client, Steven, also reported no need or desire to address REC in therapy.

The two therapists of color with White clients reported that REC had not been directly addressed in therapy with their clients. There seemed to be a tendency with these therapists to wait until the issue emerged on its own. Selina discussed how she has drawn on her experience as a person of color to better understand her client's minority status. She also mentioned that she and her client have had many conversations around privilege and oppression, racism, and heterosexism, but stated that they have not explicitly talked about the racial/ethnic differences in their relationship. "We've never done that directly . . . but I think that they've sort of emerged and we've talked about them as our work has evolved." Donna stated that she typically addresses racial/ethnic/cultural differences with clients. However, she mentioned that with her client participating in this study these

differences "haven't really come up because at this point he's mostly working through his anxiety, but I'm just waiting for something to come up, it's got to."

In terms of how racial/ethnic/cultural differences in the relationship were addressed, all but one of the clients of color reported that their therapist brought up the difference at some point during therapy. Natasha, who seemed to minimize this difference, recalled her therapist addressing their ethnic difference and her reply was "No, you're doing fine. You're doing really well right now because I wouldn't have told you anything, if things were starting out rocky." Roberto described his appreciation of his therapist's willingness to address race directly and spoke about it as a critical event in their relationship:

> He put it right on the table, right off the bat. I think the second question after he asked me how I was doing was, "How do you feel about me being your therapist and being White, and you being my client, and being non-White." Like, right off the bat, and that's another thing that I really admire was his willingness to talk about it. Because not many…I haven't come across many White folks who are willing to do that. Talking about race is almost like a taboo. So when he put it on the table, it really surprised me, and you know, I thought it was a gutsy call, and I really appreciated it. And I think that's what really started it . . . And instead of me having to almost educate him on issues of race, it was almost like he put it on me, to say how does it affect you. Almost to tell me like, "If you don't want to work with me because I'm White, you know, just put it out on the table and we can deal with it."

Gender and Gender Identity

Six of the 13 client/therapist pairs in this study endorsed differences in gender. In four of these six pairs the therapist was a woman and the client was a man, in one pair the therapist was a woman and the client was a transgender man, and in one pair the therapist was a man with a woman as the client.

Awareness of Gender and Gender Identity

All six therapists in therapy pairs with gender diversity identified gender as a meaningful difference in the relationship when asked. Three out of the six clients in these pairs initially identified gender as a meaningful difference without being prompted. These three clients all identified as White with two identifying as men and one identifying as a transgender man. The other three clients did not mention gender until asked specifically about the visible gender difference in the relationship during the course of the interview. Of the three clients who did not initially list gender as a difference, two identified as people of color, two identified as men, and one identified as a woman.

Impact of Gender and Gender Identity on Personal Identity

Five of the six clients in gender diverse therapy relationships reported that their own gender identity was not something they thought much about. Four of these clients were men, and one was a woman. These clients appeared to have difficulty responding when asked what role gender played in their own lives. Overall, in our brief discussion about their gender identities, it seemed as though their own gender identities were so much a part of them and so obvious, there had been little or no thought given to gender as a sociopolitical or cultural construct. For these clients, their gender was a given, a static physiological definition and no further exploration of issues around gender norms or roles was needed. As an example, when first asked about what role being a man played in his life, Pedro indicated that the question did not make sense to him. He later said, “When I describe myself, I don’t emphasize that I’m a man, you know? It’s obvious that I am.”

For Henry, a transgender man in a therapy relationship with a female therapist, the discussion around gender was quite different. He had clearly explored gender, gender identity, and gender expression as separate constructs that held great meaning in his life. He identified himself as queer, which he described as a political identity that also defined his gender identity, sexual orientation, and how he sees family and relationships. Henry explained, "Basically anything that is not heteronormative is queer." He went on to further describe his queer identity:

> To me, queerness is about taking every piece of identity, and, well, it's taking every piece of identity and well, in a lot of ways it's about nonconformity, in terms of my gender for sure, I would say I was gender nonconforming, and gender queer, and trans, and all of these labels that fall under queer. Queer is very much an umbrella term that captures most everything about who I am, even my job I would say is not a normal job.

Henry also talked about the overall feeling of being queer in terms of gender identity and "Just having a body that is not your traditional, normal body." He went on to discuss the tension between how he may be perceived by others and his own internal experience. He said, "The other piece of it, too, is what does the external world see versus what is true? I mean, I walk down the street and I am read as a man, and I don't identify as a man necessarily. Sometimes I do, but not all the time." Henry clarified that, for him, "identity is a lot more integral and internal, kind of one of those core things that define us, and being queer does define me. But it's not always something that I'm putting out there . . . depending on the day, and what my gender expression is like."

Two of the six therapists in gender diverse pairs spoke about their own gender identity and the role that gender plays in their lives. Both of these therapists were women, and each commented on their experience of gender norms and sexism. Diana

talked about her experience as a woman in a position of power dealing with sexist attitudes:

> There have been times when I have been, I think, initially perceived as moving into power because of the way that I look or the way that I'm dressed or something like that, although that usually dissipates after I've been able to speak for a little bit. Most people don't find me dumb . . . And I certainly have had experiences where I think that I have been targeted solely because someone doesn't like powerful women. Whether that's true or not or I'm just being targeted because they don't like me, I'll never know, but it certainly has felt that way a couple of times.

Diana also spoke about using some of the same interpersonal skills used to develop therapeutic relationships with clients in dealing with oppression related to her gender, "I think because I come across as warm or engaging, I can sometimes disarm people who would have these beliefs that women shouldn't be doing this or are not trusting that."

Selina discussed how working with her client has caused her to "think and experience and explore what it means to be female." She expressed a sense of appreciation for her therapy relationship as it has allowed her to reflect further on her own experience of gender norms growing up. Selina stated, "I was very much a tomboy. I played with boys, and I climbed trees, and my mother wanted to put me in dresses and I didn't like it. And I would climb and tackle, and come home with like grass stains and ripped dresses and, you know, like that kind of thing." She also shared an experience when as a child she asked for a wagon for Christmas but instead received a baby stroller remarking, "My parents obviously made this assumption that, 'She's a little girl and she wants to pull her dolls around. She wants a stroller.'"

Impact of Gender and Gender Identity on Therapy Relationship

Of the six clients who differed in gender from their therapists, the four who identified as men said that having a woman as their therapist either had no impact or was a positive thing. One client, Clint, stated that the gender difference has not had an impact on his therapy. Anthony and Scott reported feeling that it was easier for them to talk to a woman. Anthony mentioned that he has experienced a male therapist in another context and would prefer a woman, stating, "I feel like my personality is more understood by a woman than a man." Scott commented that he believes it is more helpful for him to see a woman: "It actually makes me feel more comfortable because I'm just real uncomfortable around guys close to her age." Scott also remarked that it can be "a little difficult, too, though, because it feels sometimes like I'm talking to my mom."

Anthony and Pedro both commented on the fact that having a female therapist's perspective has helped them improve the relationships with other women in their lives. Pedro explained, "I think it's better for me to have a perspective of a woman, because my main concerns, if I have a problem with my partner or with my mom, she will have that side that I don't see, and she will have a different opinion or approach to whatever has happened." Anthony mentioned, "She has been able to understand me better, and she understands my wife, because she's a woman, better, and I think that she's able to help us understand certain things better because she's a woman."

Each of these four men stated that the difference in gender had not been directly addressed or talked about in their therapy relationships. When asked whether he and his therapist had discussed gender, Scott said, "No we haven't since it hasn't been an issue, you know? Like if it's not broke, don't fix it." As with race/ethnicity, there seemed to be

an underlying belief with these male clients that, unless the gender difference was causing a significant conflict, there was no need to speak about it directly.

Natasha, a woman with a male therapist, reported that the gender difference did not have any noticeable impact on the relationship. She stated, "To me it doesn't make a difference." For her, feeling understood was more important than her therapist's gender. As was the case with race/ethnicity, however, after initially downplaying the impact of this difference, Natasha seemed to discuss the gender dynamic a bit more as the interview progressed. She later compared her therapist to her father and other male authority figures in her life and explained how helpful it was to experience the love, forgiveness, and acceptance she felt in the therapy relationship from an older man. This is apparent in the critical event quoted above where she informed her therapist she would require a hug at the end of each session.

Henry reported that he and his therapist have addressed gender issues directly in terms of how they relate to his therapy goals and how they impact the therapy relationship. When discussing gender and his therapist, Henry observed that, "I haven't asked [my therapist] if she identifies as queer necessarily, but I think [she] is pretty queer too." He went on to explain how his therapist seemed to communicate an understanding of what it means to be gender queer, "Just in terms of how she looks at the world, you know? Like, the choices she makes that I see at least, the ones that are visible. Even like using the word partner to describe her husband . . . I think that's a way of queering our vocabulary."

Henry said that he and his therapist talked extensively about gender identity and privilege in therapy. He commented on his own process of transformation and growth

over time and the importance of being able to process his experience throughout the course of the therapy relationship with someone who, as another person with minority status, could empathize with his journey. Henry stated, "I think we've talked quite a lot about what it means to be perceived as a man, and what it means to automatically be given that privilege. I went through that transformation of, when I first started seeing her I hadn't even come out at that point publicly, to now." He spoke about the difference in gender and the way both he and his therapist directly addressed it as a key element in allowing them to explore his personal concerns.

Henry mentioned that a more recent topic in therapy has been his reaction to others' perceptions of him saying, "How do I handle my male privilege and what do I do with that? I'm a feminist and I'm still . . . you know, I want to abolish sexism, and I want to destroy that, um, stereotype of men being violent." He shared a powerful interaction that occurred in individual therapy after attending a group therapy session where a new female member expressed concern and fear over being in a therapy group with men. Henry stated, "I had that light bulb moment where I'm like, 'I'm one of them. I'm one of the men she's afraid of! What?' It was really, really weird." He said that he was able to discuss this experience with his therapist saying, "I appreciated her challenge to examine that, examine your male privilege and…she asked me a question and this has stuck with me for a long time… 'What kind of man do you want to be?'" Henry reflected on this conversation and others that happened in therapy as he transitioned from female to male, which led him to consider:

> I've become a physical man. I'm not really just this really androgynous person walking around anymore even if I wanted to be. I get perceived as a male 100% of the time now. And so it was like, "What do I do with that?" Am I the dickhead guy who's just a jerk to everyone, and has

> [ste]roid rage and perpetuates violence, or am I kind and gentle, and compassionate, and do I uphold those more feminine characteristics that I still carry with me? I think that's a way that I queer, that I walk through the world as a queer person.

All six of the therapists in pairs with gender differences acknowledged this as an important difference. Each also noted that the gender difference likely plays some role in their therapy relationship, whether directly or indirectly. Three of these therapists reported addressing gender issues directly with their clients, and three said that it had not come up in a significant way so far. For those who addressed it directly, gender took on different degrees of meaning in therapy.

Selina stated that gender was a major theme in the work with her client. She mentioned that the difference in gender identification between her and her client may have made the development of a trusting relationship a longer process. Selina said that she felt her client entered into the relationship concerned about, "'Are you gonna get me? Do you know about this and how much do you know? Do you have experience doing this?' and not in a questioning [of] my authority, but in a like, 'How am I going to be able to trust you and do you get me?' way." She said that the trust was established in their relationship partly through other relating based on the shared experience of oppression as people with minority status. Selina commented that this led to many conversations about, "What are some of the expectations, the societal expectations, and gender norms, and gender experiences that we have as a female versus male? And how people respond to you and expect different things from us simply because of it." Selina described the conversations she and her client have had about what gender means:

> What it means to him, what it means to me, but especially for him because he identifies a little bit more on that [end of the] continuum, meaning that he identifies as male. I think many times he's really talked about saying,

> "You know I feel like I'm more gender queer and I need to identify myself as male because society only gives us two boxes, so to speak . . . And, um, and I want to have visibility and mirroring and recognition in some way in our society." But he's had to grapple with like, what does it mean to be able to have these two different experiences. And how does that shape his view of relationships, and how does that change his power within society, and how people view him?

Diana mentioned the part gender has played in enhancing her therapy relationship with a male client stating, "I think it's been helpful that I'm a woman for this particular client. He's somebody who really responds well to some warmth and support from a female and unfortunately has had poor role models . . . and really little guidance." She said that the gender difference in their relationship has been addressed directly, but at times in a less purposeful manner. Diana remarked that the difference has allowed her client to be more vulnerable in sessions, "simply because I'm a woman. I think he's a little more comfortable with that, given the relationship he has with his father, than he would have been if I were a man. So I think that's one of the things that has enhanced the relationship."

For Clark, a White, male therapist working with a woman of color, the gender difference was closely tied to cultural expectations. He commented that their work in therapy sometimes involved his client's role in outside relationships. Clark stated that their gender difference in the therapy relationship was used to help empower his client. He mentioned that, in his client's culture, "men are still largely in a position of power there, and she had kind of given in to that." Clark went on to explain that part of the therapy had to do with "trying to help her feel a little more assertive and empowered, that she didn't have to sit around and wait for things to happen in terms of relationships." It is interesting to note that, although Clark appeared to take in a more active feminist

approach to gender roles with his client, she seemed to minimize the impact of gender when it was brought up in her interview.

Three of the therapists in different gender therapy relationships reported that gender did not play a large impact. One therapist, Donna, reported that she anticipated it would come up in the future, but that her client's immediate presenting concerns, unrelated to gender, had been more central to therapy. Barbara and Dinah, women working with male clients, talked about gender roles in relation to their clients' lives and speculated on possible gender and age-based "mother transference" issues in the therapy relationship; but neither had addressed these topics directly with their clients. Barbara reflected, "I find myself thinking more about [gender] with this particular client, because I think about his sense of his role as the son and the male in an engagement relationship; so, mainly, where there are rules that he is going by that I won't deal with." As with Donna, both Barbara and Dinah commented that their clients' primary reasons for seeking therapy took precedence over gender issues thus far in their work.

Religion

Seven of the 13 client/therapist pairs endorsed a difference in religious affiliation. In general, clients in the study were far more likely to identify themselves as belonging to an organized religion than therapists. Two participants identified themselves as being spiritual with their own meaningful set of spiritual beliefs, but no affiliation to a specific religious group. The participants who identified as spiritual also stated that they had at one time been members of an organized religion but chose to leave at some point in their lives. All of the participants in this study who identified differences in religion or

spiritual tradition indicated membership in an organized religion as their primary means of determining whether a difference existed. It should be noted that, although 17 of the 26 participants identified themselves as members of an organized religion, most did not address their personal level of religiosity or adherence to their particular faith tradition.

Awareness of Religion

Ten of the 13 clients in this study identified themselves as members of some organized religion. Eight clients reported they were members of the Church of Jesus Christ of Latter-day Saints, and two clients endorsed being from a Roman Catholic tradition. Five of the 13 therapists in the study identified themselves as being affiliated with an organized religion. All five of these therapists endorsed being members of the LDS church. The therapists in this study seemed to be aware of their clients' religious beliefs or affiliations. As expected, however, due to the inherent imbalance in disclosure in the therapy relationship, several clients seemed unaware of their therapists' religious beliefs.

Six clients and eight therapists in the study indicated religion or spirituality as a difference in their therapy relationships. The six clients who noted the difference each identified with a particular religious group; four reported being LDS, and two reported being from a Catholic tradition. Some clients who did not know their therapists' beliefs speculated as to their religious or spiritual identity, typically suggesting the therapists had beliefs similar to their own. Of the eight therapists who reported religion/spirituality as a difference in the pair, three identified themselves as LDS, two identified themselves as

spiritual with no membership to any organized religion, one identified as nondenominational, and two did not identify any religious or spiritual tradition.

Impact of Religion on Personal Identity

Clients and therapists who identified as religious or spiritual reported some variation regarding how integral religion/spirituality was to their lives. Four of the clients in religiously/spiritually diverse therapy pairs, Anthony, Logan, Janet, and Pedro, stated that religion/spirituality was an important part of their lives. Speaking about his religion, Anthony, an LDS man, said, "It's a big part of me. It's a daily thing for me. It's not just a weekly thing for me. If I'm not feeling good spiritually, I don't feel good the rest of the day." Pedro, who identified as Catholic, indicated that, although he had not been particularly religious in the past, moving to a community with a large religious population has had an effect. He said, "Right now, it plays a big role in my life, which before, it didn't, and I think that's probably because I do go here and, you know, this is such a religious place." Janet, who identified as LDS, stated, "Religion is a huge thing for me. I'm very active in my church, so I feel like that's a big part of helping me become the person that I want to become." She also said, "I don't get hung up on, you know, people's religious beliefs; and I don't feel like that's something that makes or breaks, you know, a relationship."

Logan, who identified himself as Mormon, said, "My religious identity is a large part of who I am." He also indicated that he had experienced some conflict in the past integrating his religious beliefs with other dimensions of his identity. Logan noted, "Even just saying the word patriarchal. I was a Gender Studies major and my

introduction to the word patriarchy is through the phrase patriarchal blessing, and then to become a feminist who believes in their patriarchal blessing is kind of a fucked up thing." He went on to talk about his own process:

> It took a while to kind of trim that bush down into the topiary that I needed it to be in my life. It took some pruning and some working and some shaping, and until that was accomplished, I really wasn't sure what my relationship with God would be like, if I'd have a sense of closeness with God.

Jean reported some ambivalence about the role of religion in her life. She described the religious tradition in which she was raised as both a source of strength and a source of distress throughout her lifetime. She shared experiences in which she was emotionally hurt and castigated by members of her church, and yet also felt loved by other members.

Five of the eight therapists in therapy pairs with religious/spiritual differences commented on the role religion and spirituality play in their lives. These comments ranged from emphasizing a strong religious identity to admitting a vague sense of spirituality. Two of these five therapists, Bruce and Barbara, identified as active members of the LDS Church. Bruce described his religious beliefs as affecting everything he does, including when he is able to respond to clients after hours. He also emphasized his ongoing attempts to be mindful of keeping his religious beliefs from negatively impacting his clinical work, stating, "That's something that I'm constantly having to be very aware of – is that I'm not teaching them my religious beliefs." Bruce continued to explain, "My religious beliefs influence my desire to help them, and I have to be careful that that does not step over into my religious beliefs need to be your beliefs in order for you to really feel whole. So, it's a constant thing I have to remain aware of."

Barbara reported that her religious beliefs are also a very important part of her identity and that sometimes there seems to be some incongruity with others' interpretations of the same spiritual tradition. She explained, "I think there's a lot in my church that's kind of bedrock to how I think. But sometimes now I encounter people in my church saying things that are sort of night and day from what I thought was our doctrine." Barbara went on to discuss how for her, religion intersects with other identities and at times presents difficult feelings to process:

> I find myself interested in someone who's different from me and sometimes it stirs up emotions that could range from anger with my own church to gratitude to my own church, but that's an element that's usually really important to me, and I guess both race/ethnicity and religion hand me boxfuls of kind of shameful history that I have to kind of work through so that I don't just sit in an apologetic stance where it's about me, or I certainly don't think I go into the arrogant, you know, my ways are best, but anyway, for the most part, that's a welcome thing for me to have to be reflexively thinking about myself.

Kara reported having a very strong sense of spirituality and an important belief system based on "valuing life." She did not identify with any particular organized religion, but endorsed being quite comfortable discussing clients' religious/spiritual beliefs in therapy. Kara stated that her sense of spirituality was closely tied to her work with clients. She explained that for her, spirituality "creates a valuing of the other person and it creates an acceptance of their life experiences without judgment."

Arthur and Diana both reported that religion/spirituality did not play a large role in their lives. Both seemed to be able to speak about religion and spirituality with ease and each could recognize the value of religion in their clients' lives. Arthur mentioned that, "I recognize it, and I'm appreciative of it, and I give myself time to think about it. It's there, but it's not something that plays much of a role in my every day life." Diana

acknowledged the divisions that occur in her community around religion, but she also expressed a certain appreciation for the role religion plays in some peoples' lives. She explained her perspective as follows:

> I think faith is pretty fabulous. I think spirituality is pretty wonderful. I admire and envy people who achieve that, because it's certainly in ways that I'm never going to. That's not going to happen for me, ever, and when I think about the solace that it gives people, especially during really trying times, I'm really envious of that, to have that kind of, not that it's not ever shaken in individuals, but to really have that, I'm just thrilled for people who can do that . . . I think I'm more a little envious of being part of a larger thing and being able to be aware of your insignificance, as well as your importance at the same time, which I think faith allows you to do or spirituality allows you to do. I think that's pretty cool.

Impact of Religion on Therapy Relationship

None of the six clients who reported religious differences in their therapy pairs indicated that the difference in religion had a substantial impact on the therapy relationship. They stated that the topic of religion and religious difference in the relationships came up in different ways. Some clients seemed to have a vague idea of what their therapist's spiritual beliefs were or were not.

Five of the six clients said that this difference was identified explicitly at some point in their relationship with their therapist. Anthony, who identified as a member of the LDS Church, said, "Well, it's interesting, because she's told me she's not LDS, but we really haven't discussed her beliefs, but she really knows what mine are, and I feel comfortable with that. I feel she's accepting and understanding. She's not judgmental." Janet, an LDS woman, recalled that her therapist disclosed to her that she used to be LDS and left the church some time ago. Steven, who identified as Catholic, stated that the difference had not been directly discussed, but he had some idea that it was present. He

said, “I know his religious beliefs are different. I think he’s LDS. I’m not positive, but you know his religious beliefs and my religious beliefs have never ever entered our conversations.” Steven went on to say, “We just both talk about, you know . . . we both believe in God and that, and we’ve had a couple of little light conversations, but we’ve never got into anything like that.”

For some clients, there seemed to be a purposeful avoidance regarding bringing up religion with their therapists. Some clients, like Steven, seemed to equate discussing religious differences with conflict. He explained:

> I don’t like talking about religion with people, because you know, your preference might be your preference, and my preference might be mine, and that’s your choice. And my choice is my choice. And there’s no reason for me to knock you or for you to knock me. So why start an argument with somebody if you don’t have to? Especially if you like the guy, you know?

This may be due to the historically antagonistic approach taken by the field of psychology toward religion. It may also be in part the result of the dominant and sometimes polarizing presence of a particular organized religion in the local communities in which many of the participants live. Pedro, a Catholic man living in a majority LDS community, commented on this, though he noted that it has not been a problem in his therapy relationship, saying, “Many times people don’t know how to separate beliefs with professional [relationships]. Between us, that hasn’t been the case, but sometimes it happens.”

Two clients, Anthony and Janet, seemed to focus on what they saw as similarities in beliefs between them and their therapists despite the difference in affiliation being made explicit. Anthony noted, “I think she believes some of the things I believe. I don’t

know that for sure; I just get that sense." Janet explained, "The core vales that we have are similar."

Janet and Logan both talked about some trepidation about bringing up religion in therapy. Janet reported that her religious beliefs were very personal, and she was initially unsure whether it was safe to address them with her therapist. She said, "At first I wasn't sure about expressing that part. Maybe that was at first an obstacle that we faced, because I kind of held those feelings in a special place, you know, it's not something I will just talk to anybody about." She went on to say:

> As we discussed things, she told me that she used to be LDS and now she's not. And I think in some regards, that really helped me to be able to open up more to her, because she understands what I believe, even though she chooses to follow something different, yet she still has a belief in God, so I feel very comfortable talking to her about things like that, because she does have a very spiritual side to her that I've seen as we've talked. So I'm not uncomfortable bringing up religious subjects when we're talking.

Logan, who identified as Mormon, stated that he often discusses his religious beliefs in therapy as they pertain to the issues with which he is struggling. He said that although he feels comfortable bringing up his beliefs, he has a sense that his therapist is "not on board with my spirituality or religiosity." Logan went on to say:

> I talk a lot about my Mormon beliefs; I mean, and they're not just background. They are my actual, active beliefs. And I never feel like he's rolling his eyes, but I do have this moment for him … he's actually, I think, more comfortable talking about gay stuff than he is talking to me when I bring up spirituality stuff. It's just this very, very, barely perceptible like, "Oh, okay, we're going here now," and it's like he has to kind of go, "Alright, I'll go there with you."

Logan described his hesitation to bring spiritual issues up at times, but also emphasized that he usually feels comfortable enough to go ahead with it due to the trust he has with his therapist. He explained, "I always have, like, a split-second reaction where I'm, like,

'Is this important enough to bring it up?' And I do. And I usually, almost 99% of the time, I'm, like, 'Yeah, it is important and [he] can deal with it. And [he] is fine."

For Jean, religion was something that came up often in her therapy relationship. She stated that she felt comfortable discussing religion with her therapist, even though she felt her therapist did not think it was a positive influence. Jean explained that she and her therapist would typically talk about the role religion played in a respectful way, emphasizing the positive and negative impact it had on her overall sense of self. Jean shared the following quote that seems to capture this:

> I think that she feels like the church is not right for me. I do think she feels that way. And I think that when we've talked about religion and people that I've talked to, and I've said, "But they're so nice…you know, they're so nice to me." And she'll say, "Right, because they want to love you into doing it their way." Which I also do know is true.

One client, Janet, actually compared her therapy relationship to another past experience with a religious-based mental health agency. She stated, "I feel like this has been more productive than going to somebody of my own faith, because I feel like they focus … too much on the spiritual piece, instead of the whole of the person. Janet continued to compare the experiences and said that even though her therapist is not of the same faith, "I feel like I'm still able to bring those things up, but it's also the rest of the things I need are being addressed, as well as the spiritual piece of that. And it helps to be the whole of the person that's treated, not just one aspect of the person."

The therapists in religiously diverse pairs had varying opinions on how to address the topic of religious/spiritual differences. Some therapists felt it was better to have their clients bring up the subject while others were quite direct about it. Bruce and Arthur both stated that they were quite comfortable talking about religion and spirituality, but that

they typically wait for clients to broach the issue and introduce their beliefs into the conversation. Bruce, who works in a small town with some "tension" between different religious groups said, "I don't bring it up, but it comes up of its own accord. People want to know. And people are actually refreshed when I let it come up, that spirituality is actually a vital part of psychology." In a similar way Arthur stated, "It's something that I feel really comfortable talking about, but I do also recognize that it's not something that I tend to bring up with people." He did say, however, that there are times when he will bring up a client's religious beliefs, "especially if I know the people are a member of a certain religion. Or if I know that the people have religion especially in their lives. Then I will ask people directly about it, if they're not saying anything about it." Arthur went on to state, "Typically that's one where I do wait for people to bring it up. I'm not sure if that's right or wrong . . . when it does come up, I'm fine, and in fact I often feel thankful for people bringing it up, because it gives me an understanding that I wouldn't have had otherwise."

It is interesting to note that both Bruce's and Arthur's clients seemed somewhat curious about their therapists' religious/spiritual beliefs. Both clients stated that they did not know their therapist's beliefs for sure, but made some assumptions about them. Additionally, Arthur's client seemed to believe that he had some slight discomfort around addressing religion in therapy, though the client chose to bring it up anyway as it was relevant to his presenting concerns. Arthur seemed to link his comfort level in talking about religion to his client's openness, stating, "I think that his comfort with that is what makes it easy for me. And I generally was just focused on trying to understand where he

was coming from, and understanding what his beliefs are, how they work or don't work for him, or what's going on."

Four therapists with clients of differing religious/spiritual beliefs reported that they addressed religion and religious differences directly in therapy. Kara said, "I'll just bring it up and let it be there, and let them decide if they are comfortable with that." She explained her reasoning for bringing up religion with clients saying, "I think that's fair for them, because some people want to see somebody with their same religious values. And I think it's fair for them to know up front that I don't share their religious experiences." Kara could not recall the specifics, but mentioned that she likely informed her client that she was a former member of the client's religious group. She said that it is not uncommon "for me to help them be aware that I am not [a member of their church] if I think it's going to be something that they're afraid of. I mean, they can ask it if they want to, but you can often sense that question is there and I just answer it so it's clear."

For Barbara, Helena, and Diana, asking their clients directly about religion and spirituality has been part of the process of better understand their clients' worldview. Barbara said that she has asked her client on occasion if his religion is "part if this that we're talking about or does it color how you look at things? So I know I've probably brought it up. I don't know that he has, but I'll ask him, "Is this part of your culture, or what does religion have to do with that?" Helena reported that she has addressed her client's religious beliefs because they impact her psychosocial functioning. She stated that part of her role in therapy has been to encourage her client:

> to explore her own faith and her own spirituality, to explore other faiths, to explore other spiritual relationships, again, sort of in the cognitive behavioral psychotherapy type of approach of let's create some hypothesis, let's test those hypothesis, let's go out and gather some data.

> And so I do think definitely over the years the religion has been in the background or come to the forefront depending on what's happened in her life.

Helena went on to explain that she does not view her client's particular religion as the main difference, but the fact that the client is "very steeped in a single religion." She also mentioned that religion is one of many areas of life that she encourages clients to explore:

> I've had lots and lots of discussions over the years with various clients who have found that certain beliefs within their religion get in the way of their own psychological progress. And so it's a topic that comes up, and I encourage people to go out and think about it, to explore their beliefs, to really consider outside of their own set of beliefs. But I do that around every issue in their life, and not just their religion.

In a similar way, Diana explained that she often asks about religion in addition to other differences as a way to further her understanding of clients:

> What I try to keep in mind is anything I don't understand, to kind of pursue with some line of questioning so that I can understand. So some of those are big differences, like religious differences, or some of those are more subtle things, like how you spent that part of your day or something, so I think that's kind of my philosophy, you know, is to come up with hypotheses about what's going on, but in order to do that, I need to have information, and then I need to check out my hypotheses, which might involve even more questioning or a deeper explanation of the difference so that I understand those kinds of things and really understand what's helpful.

Whether they chose to directly address the difference or not, some therapists discussed exploring if their clients' religious/spiritual beliefs were important sources of strength and comfort. These therapists seemed more likely to work with their clients' belief systems and integrate spirituality into the therapy process or simply move on to other, more salient aspects of their identity, if not. These therapists also appeared to have an accurate sense of the role religion/spirituality played in their clients' lives. Kara spoke

about her client saying, "I do value her religion for her. It works for her. She is involved in it and she finds a lot of strength in it, and I'm okay with that. I don't need to challenge that." Diana shared an incident regarding her client's wife, in which she explored a religious practice as a possible coping strategy. She said, "I asked her if she'd been to the temple, just knowing that that would likely be very helpful and give her a lot of solace. It's a coping strategy that I think is good for her, but it's not necessarily one, had they not been my clients, that I would have known about." Bruce summarized his view of working with clients' spiritual beliefs in therapy:

> When people mention that they draw strength from something, I try to capitalize on that. Because they need all…if they're showing up to see me, they need all the avenues of strength that they can get. And if they can get that both from their spiritual teachings and also from the social religious aspect – the support they need there, I am definitely going to take advantage of it. And use their own doctrine that they bring in as reasons for engaging in things like accepting of their own internal processes, that [in] almost all teachings, [it] turns out that's an okay thing to do – in fact a recommended thing to do. So I take advantage of it.

Two therapists mentioned being aware of a difference in religion/spirituality in their therapy relationship, though their clients did not. Selina commented that she identified as being very spiritual and noted that her client was "exploring a range of things." Oliver stated that he thought his client, who identified as a member of the same religious group, was ambivalent or possible rejecting of this belief system. He recalled, "I think I'm right about this . . . he doesn't have faith, and he doesn't believe in [this religion] anymore. So when he told me that, I had no particular reaction and I think that helped. Because clients don't want to have to come in and do battle about such things."

Oliver, who works in an agency that is affiliated with a specific religious group, spoke quite extensively about how he typically addresses religion and spirituality with

clients. He seemed to draw a firm line between therapy and "preaching," taking his cue on whether to incorporate religion from his clients. He said he is very cautious about "not letting any kind of religious stuff leak into the therapy, unless they want it. Now if they like it, if they are very religious themselves, then it will be almost like pastoral counseling. But if not, they wouldn't know what my beliefs are at all, without asking." He also spoke about self disclosure and exploration with clients around religion:

> Now this doesn't happen as much anymore, but occasionally people will say, "Well, are you [a member of my church]?" I kind of like it when they do that and I say "Yes," but I don't want to have them have some preconceived notion of what they're going to get when they get here. Because clients here at [this institution], there's no shortage of them getting preached to. So they don't need to be preached to about religion in these offices, not at all . . . But I'll say, "Are you religious? What does that mean? Is that part of this?" I might say. So I would say, "Are you religious?" or, "Are you a member of the church?" . . . "Do you believe it?" I always put that in, "Do you believe it? How much?" And I pretty much ask it the same way every time, because I'm not out to influence their answer.

Age and Experience

Several participants identified age and experience as an important and meaningful difference in their therapy relationships. Among the 13 therapy pairs interviewed, over half had a difference in age of 10 years or more between client and therapist. A number of clients seemed to discuss the age difference in terms of experience. As the following quote from Pedro illustrated, there was a reluctance to refer to therapists being older. He said, "I enjoy talking to people that have experience … I don't want to say older, but people who have experience." This may be due to cultural norms and perspectives on what is considered polite when referring to someone's age. So, in this subtheme, using

the participants' language, age and experience are both used in reference to differences in age in the therapy relationship.

Awareness of Age and Experience

Overall, clients in this study seemed to be more aware of age differences than therapists. Eleven clients and eight therapists identified a difference in age and/or experience as a factor in their relationship. The difference in age between client and therapist in these pairs ranged from 2 to 37 years. Some clients mentioned noticing a minor difference in age and commented on the implications of that, whereas others talked about how a major age difference impacted their therapy relationship. For a few clients, this difference seemed the most salient to the relationship dynamic.

One interesting note about age is that there seemed to be a reversal in the pattern of awareness around this difference. Unlike some of the other traditional demographic categories identified as differences by study participants, such as race/ethnicity and gender, clients appeared to be more aware of the difference in age as well as the implications for the therapy relationship. Two therapists who were 15 or more years older than their clients failed to mention age as an obvious difference until prompted.

Impact of Age and Experience on Personal Identity

Only two of the eleven clients who identified age/experience as a difference had anything to say about the impact of age on their identity. The other nine clients seemed to have considered age solely in relation to their therapists and not as it pertained to their current identity. These two clients, Scott and Warren, were both in their mid-twenties.

They both indicated being at a "transition point" in life and looking ahead to future goals. Scott said that his age per se did not hold as much meaning as "where I am in life" as far as goals achieved. Warren stressed the role of "progress" in his life. He stated, "So it's like I know who I am, but at the same time anything can happen and what I do now is pretty important."

All eight of the therapists who discussed age commented on how age impacted their personal identities. Some therapists who had given this subject some thought had quite a bit to say. When asked how age impacted his identity, Oliver said, "I'm surprised at how damn old I am!" He went on to say, "I wouldn't want to give up what I've learned and what I earn. I wouldn't want to give that up, or trade it. So I see it as sort of the wrapping paper, the box, an inevitable part of life, so that's my sense of what it means and how it affects me." Oliver also speculated about the effect of his age on clients stating, "I think a bit about what are these young people going to think when they come meet with me?"

Four of these therapists mentioned the impact of realizing they were old enough to be their clients' parents or grandparents. Kara remarked, "I'm old enough to be [my client's] mother. I've got children her age." She went on to say, "It was odd when I started having patients who were adults who came in and I knew they were in high school with my kids . . . And the other odd thing was when I had patients come in whom I've seen their parents when they were first married." Oliver talked about his experience of seeing clients quite a bit younger than him. He shared, "I remember arriving at the point where I was, like, twice as old as many of my clients, right? Now I'm three times as old as many of my clients, so I'm a grandpa, almost. I could easy be the grandfather of many

of my clients, which sort of strikes me." He also noted, "So they come from obviously a different culture than I come from, the youth the culture…and that gap is a big one now, so that's a big difference."

One therapist, Dinah, reflected on how she enjoys her current age and the ways in which it influences her perspective on younger people, especially clients. She said, "I actually really like being this age. I'm quite healthy, and I probably would feel differently if I wasn't, but the things I love I can still do." She joked, "I call myself middle-aged, which is probably a euphemism. One day my husband said, 'You know, Dinah, technically that means you're planning to live to 114 . . . and I'm not!'" Dinah further commented:

> I feel like it's a nice time of life in a lot of ways. I feel like I've had a lot of rich life experiences, and rich life relationships; and I love being my age. I feel toward younger people, I feel really . . . I really wish to help people coming in along behind me on the conveyer belt. You know, I really wish people well. And I really love working with college students, because it's such a great time of life to solve something, or to make progress, or explore. If they could put an anxiety problem behind them, or make big steps at this stage of life, the next 50 years can be so much more fun. So I feel quite benevolent and hopeful for young people. And it's a great time of life to work with people that age. I think of them . . . my mental word is kids, and I have to be careful not to say it out loud, because I don't mean it disrespectfully. I mean it like my kids. I mean the word with great affection and that my relational way of looking at people, toward the younger generation, is relationally with pretty unimpeded hope and well-wishing, you know, benevolence. And this age of life is . . . it's easy to do that.

Two therapists, Kara and Donna, did not think of age being a substantial difference at first. Each reported that they don't often think of themselves as being their chronological age. When listing differences between her and her client, Donna said, "Age also, he's slightly younger than me, I think he's in his thirties. Well, God! I guess he's way younger than me! I forget that I'm 50. He's much younger than me, so I think

that's another way that we differ." She continued to remark, "I think it's easy to forget that. I think internally, for example, I'm still like 27 or something." Kara reflected on age as a difference when asked and commented, "I never even think about that question, so I'm wondering if it's an issue patients have that I'm completely unaware of." She said, "Because I don't feel that I am [significantly older], so I don't have an awareness of it, particularly, for myself. That would be an interesting thing to know. Most of my patients could be my children, but I don't think of it that way."

Donna also commented on her own chronological age and her perception of what it means to be that age. She noted some incongruence between how she sees herself and her idea of others that are her age. Donna explained that upon consideration age is pretty important "because I really don't feel my age. Stereotypically, I think of 50-year-old women in a certain way, and 50-year-old psychologist women in a certain way, and I don't fit into that perception that I have. So that's pretty, that's actually a pretty big one for me."

Bruce, a therapist in his mid-thirties, brought up the issue of being perceived as younger than his actual age by most clients. Because he appears much younger than he is, Bruce stated that this can bring up issues around credibility and or the capacity to relate depending on the client. He said, "I'm 36, frequently mistaken for being fresh out of undergraduate school, literally." Bruce mentioned, "It's frequently an issue that's difficult for the clients to overcome. And they only move past that after a few sessions, and realizing that I'm useful to them. And then the age drops away, I think. At least it doesn't come up again."

Impact of Age and Experience on Therapy Relationship

All eleven clients who commented about the age difference in their therapy pair also made some mention of age having an impact on the relationship in either direct or subtle ways. Clients also reported that this difference was addressed differently across therapy pairs. Three of the eleven clients who spoke about the age difference said they could recall some mention of it in the relationship. The other six talked about their awareness of the "obvious" age difference, as Natasha described it, but could not remember having a conversation about it in therapy.

Warren, Scott, and Clint each said their therapist attempted to make explicit the difference in age or experience. Warren recalled his therapist using humor to comment on their age difference. He said, "I took a geology class, and it was all about dinosaurs and fossils, and everything. And so I'm pretty sure he cracked some joke about him being older than a dinosaur, I don't know. But we didn't really address the difference. Not that I can think of." Scott reported that his therapist often made reference to their difference in "generation" as a way of checking in to see if they understood one another. Clint stated that he remembered the age and experience difference between him and his therapist being brought up in therapy as a parallel to the age difference in his marriage. He said his therapist also used this difference as a way of challenging him to be open-minded by saying, "Well, I'm older than you, I've gone through so much more than you. I've had so many more experiences than you . . . Would you be open-minded to that, or would you say, 'You know what you're full of it?'" Clint reported this explicit mention of age was helpful remarking, "I was actually open-minded to it, because she has experienced more."

Of the therapists who noted the impact of age on the therapy relationship, Oliver was the only one spoke about addressing this difference explicitly with his client. The other six therapists, most of who reported addressing other differences directly, speculated on potential dynamics around age but did not seem to bring it up as a separate issue with clients. Oliver, who often works with clients significantly younger than himself, described the way in which he typically goes about bringing up the age difference with clients:

> I'd probably be quite overt about saying, "Well there are obviously going to be some differences between us, and what we understand and so on, and I just have to depend on you to let me know if I'm missing the boat in something or the other. I'm not going to try to jump into your lingo. I'm not going to try and seem hip or anything, but if I'm really misunderstanding something I hope you'll let me know" . . . So I try to acknowledge that I'm not of their generation and try to get some help understanding how they talk to themselves, and bridge that divide by talking with them about what is an obvious divide.

Nine of the eleven clients who noted that age and experience had an impact on their therapy relationships talked about it as a positive factor. Two clients talked about both positive and negative implications of the difference in age between their therapists and themselves. Janet talked about the benefits of her therapist being older, stating, "She has a lot of experience that I don't have, which I think adds to what she can offer me . . . I think that's the biggest part of age that's come up is she just has more experience." Janet also remarked that her therapist has been through things that she has not and "can offer that experience, not just her training, but 'I've walked in your shoes and this might work and it might not, but it's worth trying,' so to me, that's huge, because if somebody's tried it and it worked, I'm willing to try it!"

Pedro, in speaking about his therapist being older, said, “She’s way older than me, right? When you talk to somebody that is more experienced than you and they have that interest in helping you, I don’t think they really want to harm you . . . They just, they really want to help.” He went on to say, “[She has] a lot more to say, to bring to our relationship, than somebody that hasn’t had that experience. I see that as an advantage.” Natasha compared her therapist to her father, stating she appreciated the “counsel” he could provide. Clint also mentioned the “age difference” and his therapist’s “experience with life, having her own kids, and having the years of experience working with group therapy, and individual, and couples” as, from his perspective, being one of the most helpful factors of their relationship.

Four clients discussed the importance of their therapists being slightly older or younger than them. Donald said his therapist was “a little bit older” and compared him to a “big brother” who could provide advice and mentorship. Steven, who perceived his therapist to be only a few years older than him remarked, “He is younger and his approach toward me is really friendly.” Logan speculated his therapist to be about six years older than him and mentioned the great impact this had on their relationship:

> You know, professionally . . . he’s a little further along in his career, and he’s a little older than me. I really like that, because he knows where I am and can give me advice on kind of developmentally what my life is going to look like, not only just in my development as a psychologist, but like, “You’re 31, I’m 37. Let me tell you what the next six years might look like for you.” I mean, he’s never done that, but he can also see where I am developmentally. That’s a difference that I think has been great. I mean, if he were 70, I think he would have very limited perspective; but whereas he’s somewhat near my age, I think he remembers pretty quick, and clearly what my next steps are going to be.

Scott and Warren, who each had older therapists, both commented on the positive and negative implications of the age difference in their therapy relationships. They each

mentioned age as a potential barrier to understanding, but also valued their therapist's experience and knowledge. Scott, who reported having a close and "personable" relationship with his therapist said, "I guess it's just the generation – you know I have a different understanding of the world than she has. And it's not just because of our different experiences . . . but just because the world was different when she was my age. He also explained, "I guess I don't feel like that particularly causes conflict. That's probably something more of what I enjoy because then that helps me….I assume she's had more life experience."

Warren seemed to experience the age difference with his therapist as more of a barrier. He described his therapy relationship as more "professional" rather than personal. In discussing challenges in the relationship with his therapist, Warren shared that the biggest challenge was the "age difference." He said, "I could tell that he is keeping up with media and the technology and everything, but . . . he's been doing this for a while, so it just made things seem a little less personal, and more response from experience with other people rather than me." Warren also mentioned, "I know there were a few times where he would say something like he was trying to connect with me at my age level . . . Trying to just like assume what I want, because I'm 22, or what's on my mind, what my goals are, stuff like that." Despite this barrier, Warren reported having a significant amount of trust in his therapist's experience. He said, "And even though sometimes maybe it seemed rehearsed, or the experience in him was coming out, it was a good thing because I could trust that he knew what he was doing, and what he was saying made sense to me. So there was some security in that."

Most of the therapists who acknowledged that age was a meaningful difference in the relationships with their clients did not seem to have given much thought to the impact of this difference. Kara summed up several therapists' reactions to the age difference in the following quote: "I might need to be more aware of this, because I'm completely unaware of this as an issue . . . Maybe I'm very unconscious of this . . . I know there is [a difference], but I don't think about it that much, because I don't feel as old as I am."

A few talked about using the age difference in therapy. Clark, whose client is younger, spoke about his awareness of some father transference from his client and the benefit of "working through the transference in a therapeutic way." Bruce discussed the benefit of his youthful appearance with his client. He said, "I think in this case it served me because I think this individual's had struggles with a lot of people he's worked with maybe being too paternalistic or too maternalistic, and so it was nice try and meet somebody on the same grounds." Bruce also shared that although his young appearance has sometimes been a challenge with his client in terms of maintaining professional boundaries, "it also creates an in – that he feels that I can relate . . . I look like I'm his age even though I'm a lot older than him. I probably look younger than him in fact . . . So I think that one has served, in this case, I think it's been a real benefit."

Socioeconomic Status

A difference in SES was noted in six of the 13 client/therapist pairs. Participants who mentioned this difference typically referred to income level or perceived income level. Some participants, however, included education level and employment status under the larger umbrella of SES when discussing their perspectives on the meaning of

this difference. Therefore education level and employment status were subsumed under the broader subtheme of SES.

In five of the six pairs in which SES was listed as a difference, therapists were perceived to be in the more socially desirable role of having higher SES. In one of the six pairs, the client was perceived to be of higher SES despite recent financial problems and perceived as having been raised in a family with a much higher SES.

Awareness of Socioeconomic Status

Four clients and five therapists reported SES as a meaningful difference in their therapy relationship. Clients did not talk much about this difference other than to simply note its presence. When mentioning differences, Jean remarked, "In terms of demographics, I'm sure that [my therapist's family] have more money than I do." Roberto referred to the difference in SES between his therapist and him as a difference in class. He recalled, "We're from a different class. You know he's already a working professional. At that point [of the initial start of the therapy relationship] I wasn't. I was a student." Henry, who earned a Bachelor's degree, mentioned the difference in education level with his therapist.

Therapists had more to say about the difference in SES. In speaking about differences, Barbara noted that her client had discussed significant financial concerns with her. She described this difference in terms of "access to resources in our culture and . . . SES." Bruce commented on the difference in SES with his client stating, "I don't know that he's ever been to my house - but his house could fit inside my house four times over. That's a pretty big difference." Diana, whose client comes from a "wealthy

family", noted that one of the big differences between her client and her has been "SES - both in terms of how I grew up and how he grew up, as well as current SES." Hal also discussed the difference in personal circumstances with his client stating, "Higher education, for him, has been … more difficult because of the fact that he's a single father . . . He works full-time. He helps pay for part of his family's economic situation. That's just not like me. I mean mine was very different."

Overall, therapists appeared to be more aware of the potential implications of SES differences; however, it may be that therapists were simply more comfortable discussing this topic. In addition, therapists typically have much more information regarding their client's lives, including income level, than clients would have about therapists. It is likely that many clients also assume (however inaccurately) that psychologists, as health care professionals with advanced degrees, have high income levels.

Impact of Socioeconomic Status on Personal Identity

The four clients who expressed some awareness of SES as a difference in their therapy relationships did not have much to say regarding how SES impacts their identities. Roberto seemed to be the only client who had previously reflected on this issue extensively in relation to his own life. However, it should be noted that this may be more of a reflection on clients' overall comfort level with issues around SES or willingness to talk about it during our interview than lack of consideration. Roberto discussed the importance of "class" and how it has interacted with race in his life. He stated that, for him, class is an issue "you could navigate through, in and out, because, depending on what class you are, the higher up you go class-wise there's clearly the

ability to navigate certain spaces. Whereas, when you're dealing with race, those invitations can easily be taken away from you." Roberto contrasted his personal experience of race as a more "fluid" construct than class, which is more static and material-based, observing, "You can buy a house in the east side, and no one is going to move you to the west side. You have the ability to stake a claim in that space. It doesn't really matter that you're brown, as long as you can afford it, you're there."

Four of the five therapists who mentioned a difference in SES in their therapy relationships commented on how this issue impacts their sense of self. Barbara reflected on her circumstances, saying, "I feel very safe in my world. In some ways I don't, you know, whether I have money to pay next month's mortgage payment is pretty set. If I didn't have money, I could probably find kindhearted people to help me out." Bruce also commented on his SES in comparison to that of many of his clients. He shared, "I do sometimes become embarrassed that they could literally look up the hill and see my house from their house. And they're having financial difficulties. Who am I to help them with their life? That runs through my head."

Hal, Bruce, and Diana each talked about their background and how their family circumstances and SES influenced their sense of identity. Hal stated, "I was this White, heterosexual male who went to private schools all the way up until I went to graduate school, and it was never even an issue of whether I was . . . going to be in school. I didn't have to worry about financial stuff." Bruce also talked about the privilege he experienced growing up and how it allowed him to succeed:

> I've always been very comfortable. I can say I did it on my own two feet. I worked lots of jobs. I worked lots of graveyard shifts and all that. But I had the opportunity to do so. And I had the training growing up to teach

> me that I could do that. So I can say, well I did it myself, but I was pretty darn lucky to have been trained how to take care of myself.

Diana shared the following about her sense of self regarding SES:

> The socioeconomic status I think has a huge impact on my identity. Being raised in a blue-collar family and yet moving in a world to where I'm typically with highly educated people or some of my other aspects of the job bring me with people who have lots of power in the state of Utah. And I think that's had a huge impact on my identity, too, in terms of moving in both worlds and yet having some pretty grounded values, I think, that are much more stereotypical of the blue-collar type of roots of things. Those are the things that are probably most important to me, work ethic and, being the kind of Midwestern type of view of you don't really talk about yourself unless asked, or if you do, it's just really not anything, you don't brag, you don't say things about your accomplishments, the value of money, I must save it, in terms of saving money, you know, that kind of thing comes from that blue-collar philosophy and having to go out on my own when I was 15, so I think those things have had a huge impact on my identity and are very different than [my clients'].

Impact of Socioeconomic Status on Therapy Relationship

Most of the clients and therapists who identified SES as a difference in their therapy relationships did not indicate that it was addressed directly. Two clients and three therapists talked about this difference having an impact on the relationship. Jean mentioned that her therapist had more education and was likely better off financially than she, but she noted that it has "not ever seemed to be a huge difference between us." She also explained that her therapist has never been "the type to lord it over you." Roberto, whose awareness and identity development around issues of race, class, and power was quite advanced, stated that although the difference in class between his therapist and him was a potential barrier at first, it was secondary to race. He said, "I think I was so concerned with the race aspect of it, that once that was dealt with, class didn't even matter anymore." Roberto also remarked, however, that his advanced education level

had played a critical part in overcoming differences around race and class with his therapist.

The three therapists who discussed the impact of SES on their therapy relationships focused on their efforts to truly understand their clients' life situations and worldviews. Barbara shared a story her client told her about going on a trip and not having enough money for bus fare. She then said, "For me to then enter the world of someone with that kind of financial situation where, you know, just a bus fare is not always there, it, to me is just a real challenge to really get it, but I want to." Diana said that in terms of SES, she and her client have not "put to rest" the differences in their upbringings. She did state, however, that they have addressed current SES issues in therapy "with my inability to relate to millions of dollars and asking him questions about what this would mean and how this would work and some of the things that he's involved in and some of the consequences of some of his business dealings and tradings." For Bruce, there seemed to be a degree of discomfort with the difference in SES between him and his client:

> He invites me over for BBQs…ethically I wouldn't do it – invite him over to my house for a BBQ, just because that's inappropriate. But also because I would feel almost a sense of shame, like "Wow – my back porch is as big as your living room." And it hasn't come up with him, by the way. That's all in my head. But I don't know… he's a definite blue-collar worker. Has grease under the fingernails, hard worker. And I've done all that stuff, but it was temporary, and I knew it was temporary when I was doing it. This is his livelihood, being a mechanic, and it's not going to change. That is going to be his livelihood in the future.

Sexual Orientation

Three of the client/therapist pairs endorsed sexual orientation as a meaningful difference in the therapy relationship. In each of these three pairs the clients identified as gay or, in one case, queer; and the therapists identified as heterosexual. The clients in these relationships seemed to be quite comfortable talking about their sexual orientation during the interviews, and there did not appear to be any attempts to ignore or minimize this difference as was the case with other categories of difference, such as race/ethnicity, in which clients identified with a minority status.

Awareness of Sexual Orientation

In each of the three therapy pairs with sexual orientation diversity, both client and therapist identified this difference as meaningful. Two of the clients identified as gay men and one client identified his sexual and gender orientation as queer. The three therapists, two women and one man, each identified themselves as heterosexual or straight. There seemed to be a balance of openness and acknowledgement of this difference in all three therapy pairs that was not present in other areas of difference addressed by participants in this study. This may be due to the overall level of identity development of the six individuals in these pairs and/or the strength of the therapeutic relationship rather than any inherent quality related to sexual orientation.

Impact of Sexual Orientation on Personal Identity

Each of the three clients in therapy pairs with sexual orientation differences discussed their orientation as an important dimension of their identity. As is often the

case for individuals with majority identities, the three therapists did not identify their sexual orientation as an important part of their lives. Two of the three therapists had little to say about their own sense of being heterosexual aside from the fact that they were all married to opposite gender partners. One therapist, Dinah, reported, "I think I take it respectfully. The fact that I'm in the majority position and not the minority position on that . . . I try to look for blind spots." She seemed to empathize with being in a minority role based on her own life experiences, saying, "I have some sympathy in general for being in a minority position. But it's so different when it's relationship based. So I listen as much as I can, I try to watch myself and learn, I've learned so much from [my client]."

These clients talked about having come to terms with their sexual orientation and some of the conflicts they have experienced as a result. Henry, who identified his sexual orientation as queer, recalled going through a lot of changes in his identity throughout his therapy experience. He said, "When I first started seeing [my therapist], I believe at that time I don't know how I identified in terms of sexual orientation. Or if I did identify, or how . . . I don't think even said it. I guess I was lesbian at that time. I never liked that label for myself. It doesn't fit." He talked about the process of coming out to his parents and becoming very active in the LGBT community. Scott, who identified as gay, commented on the journey he has experienced to get to the point where his sexual orientation was an "important" part of himself and also something that he viewed as "out of my control, like my age."

Scott and Logan, who also identified as gay but currently in a committed relationship, discussed having to navigate through conflicts between their sexual orientation and their religious beliefs. In speaking about this conflict, Logan said, "I

would say they are equal parts of my identity. And I used to face a lot of conflict integrating those two identities, but I don't anymore, at all." Scott did not seem to be as far along in this process. He stated, "I already know that I'm gay. I can't change that. It's not going to change, but I'm just trying to understand what the role the church is going to play in my life, and how my spirituality is going to grow and progress." Scott also shared how this conflict has impacted his relationship status, saying, "I mean there's a lot of conflict because I'm gay but then I'm Mormon, and I kind of want to still be Mormon, but then I can't get married, but I don't want to be alone."

Impact of Sexual Orientation on Therapy Relationship

All of the clients and therapists from these three pairs described how the differences in sexual orientation impacted their relationships in therapy. Therapists talked about their efforts to understand their clients' perspectives and relate to their experiences; and clients stressed the importance of feeling accepted and validated for who they are, particularly around their sexual orientation. Three of the therapists reported addressing this difference directly in the relationship. One therapist, Selina, described it as a strong theme in the work with her client, but stated the actual difference between them had not been discussed directly. She said, "I have never portrayed myself or pretended to be gay or lesbian or bisexual. I wear a wedding ring so that it's very clear that I am heterosexual and . . . he's never asked me, but I've never hid anything and so it's never come up as part of our relationship." In addressing the difference, Dinah stated, "I don't remember that it was right away. He was pretty depressed when he came

in, and so we were doing symptom kind of things. I remember that it was kind of a gradual start-up into the sexual identity issues."

Arthur reported that his client was the one who initially brought up sex and sexual orientation in their relationship with some assertiveness, which for him was "atypical" of clients. He said, "I think it was within the first few minutes, he started talking about sex and he was talking pretty explicitly about sex. And all of a sudden he turned to me, and he was like, 'I hope you're ok talking about sex, because I'm going to be talking about a lot of sex in here.' Arthur recalled being slightly "taken aback by just that comment, and the way he said it," but felt grateful for his client's willingness to open up. He went on to say, "Those are like the peripheral details of what we're working on. I mean it's relevant, but it's not the heart of the matter. I would say the heart of the matter is my relationship with him, and how that facilitates the, kind of working on the issues that are important to him."

Arthur and Selina also commented on the importance of their clients' feeling safe, as sexual minorities engaging in therapy with heterosexual therapists, and perhaps testing the relationship at first. In commenting on the difference in sexual orientation, Selina stated, "I think that that also can create a barrier in some way, right? Like, 'Are you gonna get me?' And so there's a little bit of that testing component." Arthur explained his thoughts on the start of his relationship with his client and the conversation around sex and sexual orientation:

> He needed to see if I was going to be safe to talk about those things … and certainly that's an issue, that's a part of his life . . . If I was uncomfortable with that, he was going to know right off the bat, and he was also going to know that I wasn't the right person for him. He needed to have someone who was comfortable with that. That was sort of a starting place, you know? So whether or not it was a deliberate attempt to catch me off

> guard, or anything like that, I don't see it as that, but more of a safety sort of thing.

When asked about how the difference in sexual orientation might have impacted his therapy relationship, Arthur related this back to the basic connection he felt with his client. He indicated that, although he and his client talked quite a bit about sex and the client's identity around sexual orientation, the difference between them had not been explicitly discussed in session. Arthur summarized his perspective:

> It doesn't feel like it's something that we really address. But it also doesn't feel like it's something that we need to address. I think if I felt like he was concerned about, like if I was getting the sense from him that he was feeling like I wasn't getting him, or that he was worried that because I hadn't been through his process of coming out, or like, or I've never had sex with a man, you know. If I felt like that was bothering him in some way, then certainly I would be addressing it more, and making sure I did understand where he was coming from. But I've never felt that that was an issue. It's felt like we've connected, and to me that's what matters most. Like, if we're connecting, then it kind of feels like other things fall into place.

Logan and Scott both talked about establishing trust with some initial testing of the relationship. Scott remarked that "being open, even with a therapist, is still hard." He stated that he had not disclosed his sexual orientation to all of his previous therapists, but he said, "I think I've learned to just, you know, be open and honest about that, otherwise therapy's not going to work." Logan recalled, "I mean, initially, I did engage in some sort of testing behavior the first couple of sessions to establish trust around sexual orientation." He mentioned the importance of "gauging his level of comfort talking about the gay stuff, my relationships, sex, you know, club stuff, my religious issues surrounding sexual orientation, and he demonstrates just real comfort and ease when discussing those things." When asked about this, Scott, whose therapist works in a religiously affiliated setting, recalled some testing behavior, but admitted that "I do that with everyone." He

also talked about being mindful of his therapist's reaction to his sexual orientation issues, stating, "I try to see what she thinks of things . . . I test the water, not that I don't think it's ok to talk about, just because I don't want to freak someone out. But I would say I'm a lot less cautious with her, because she's my therapist." Scott continued to say, "But I just kind of watch her reaction to things I have to say; and if I feel like she's relaxed enough, then I just keep going. And she's usually really good at being relaxed, even if maybe she's not."

Henry discussed the importance of his therapist being a consistent source of support as he worked through the process of coming to terms with his own identity. He said, "She saw me through coming out to my parents, and then transitioning top surgery, and then taking testosterone, a lot of different stuff has happened in the last year and a half. He went on to say, "And she's kind of just been a calm rock in the midst all of it, which is really comforting more than anything . . . I like that I'm going throughout all this change, and [my therapist] is calm and good and solid, and looks the same, acts the same, it's just like very consistent." Additionally, Henry commented on "knowing that I can call on [my therapist] to be active as an ally, and as a therapist - a therapist ally here locally within the community is big as well."

Scott described his therapist's attempts to understand his conflict around sexual orientation. He said, "It's one of those things I feel like, unless you're in that situation, it's very difficult to be able to understand what that person is feeling." He also commented that he and his therapist have talked about his conflict around "this inability of me to get married to a woman and have a family, and stay active in the church." Scott stated, "She's telling me, 'You know, you can have a fulfilling life without that,' but…

You know, you grow up, the church lays out a plan for you, you know this is part of the plan of salvation . . . and when realize you can't, it's kind of a big crack in the skull." Scott also stressed his appreciation that his therapist "tries really hard to understand." He shared a critical event that occurred for him in therapy when his therapist shared a personal experience in order to connect and empathize with his struggle:

> One that was really touching for me was, because we talk a lot about, because I'm gay, and Mormon – that whole dilemma. And I struggle a lot with why you know, this happened, and what am I supposed to do? How am I supposed to…you know…what is my part in the role in the plan of salvation with God and all that stuff? And she talked about how [a member of her family] passed away from cancer and how those type of thoughts went through her head, and, you know, how she reacted to it. That helped me. I guess that made it so much more personable, and it helped me trust her more, and then, you know, after she did that, she just offered suggestions of how I could cope with it instead of just, you know, "Oh, that's hard."

Logan also commented on his therapist's nonjudgmental approach toward sexual norms in "gay culture." He said, "He does a really good job of getting that and being okay with that, but I can tell that's not his worldview." Logan also shared, "He never reacts with any kind of judgment . . . he does a good job of seeing me and my choices and then also the cultural context I'm in." He went on to explain that his therapist has never challenged him on any aspects of gay culture or asked him to reconsider any cultural elements, "which is kind of funny. I do that with my own gay clients." Logan also observed, "If [my therapist] were gay, I'd be okay with him saying [that] . . . but I don't want to talk about that with [him]. That would feel weird. It would feel judgmental. It would feel very homophobic." He then made an interesting observation about the relationship dynamics around this:

> I'm sure that has everything to do with power dynamics, because when I'm with my straight male clients I'll analyze, you know, sort of their

> discourses with them, too. But I think that as a gay person, I can do that because you all have all the power. So . . . I've appreciated that about [my therapist], and [he] has never said anything like you know, "Gay relationships seem to face these challenges." He's never made these kinds of generalizations. He is really conscious of the power, probably.

Relationship Status and Relationship Orientation

Although eleven of the therapy pairs in this study contained differences in relationship status, only seven participants identified this as a meaningful difference. Additionally, in only one pair did both members identify this as a meaningful difference. In each of the other five pairs where it was mentioned, either the client or the therapist listed it, but not both. For some participants, this represented a significant dimension of difference, while others seemed to simply mention it in passing as they listed off every difference they could name. Therapists were more likely to acknowledge this area of difference, perhaps because of the imbalance of knowledge about their clients' personal lives. Clients, however, were more likely to identify this as a meaningful difference and discuss the implications.

Relationship orientation was identified by one therapist as a meaningful difference in her therapy relationship. This construct is different from relationship status which traditionally refers to one's level of attachment or intimate/committed partnership (e.g. single, partnered, married, divorced, etc.). Relationship orientation was defined by the participant as an overall approach to intimate relationships, specifically polyamory vs. monogamy.

Awareness of Relationship Status and Relationship Orientation

Five therapists and two clients identified relationship status as a meaningful difference in their therapy relationship. For the most part, the therapists mentioned the difference was present and did not explore or speculate beyond that. Diana and Kara, who both identified as divorced, had typical comments. Diana simply stated, "That he's married and in a committed relationship is a difference as well." In listing differences present in her therapy relationship Kara said, "The other one could be that I'm not married. I don't know if she sees that as a difference. I don't know."

One therapist identified relationship orientation as a meaningful difference. Selina, who identified as being married, listed relationship orientation among a number of other differences between her and her client. She shared that her client "really believes in and often practices polyamorous relationships, and I am very much in a monogamous relationship." Selina's client did not identify relationship orientation as a difference in their relationship. However, her client did ask, after the interview, why there was not a question about relationship orientation on the demographic questionnaire participants completed prior to each interview.

Two clients, Scott and Logan, who both identified as gay men, identified relationship status as an important difference. When discussing differences, Scott listed a few and then said, "Oh, another difference is I'm single and she's married. That's an important one." Logan mentioned, "I like that [my therapist] is in a long-term relationship and married with kids and I'm not. I mean, I've been with [my partner] for a year and a half, but that is a difference that I actually really like."

Impact of Relationship Status and Relationship Orientation on Personal Identity

One therapist and one client commented on how their relationship status impacted their personal identities. Dinah, a therapist who identified as married, shared the great personal importance of her marriage and her family in her life. She said, "I value relationships tremendously. My family … and my husband…is the center of my emotional life, in ways that are so foundational I can't even put them into words." Scott, who identified as single, gay man, stated, "The relationship status…that's something I have a choice in, but that's where there's a lot of conflict, I guess. It's important to me, but . . . there's a lot of conflict in there because I mean it's a choice, but my choices are different, I guess, limited."

Impact of Relationship Status and Relationship Orientation on Therapy Relationship

Two therapists, Kara and Dinah, talked briefly about how the difference in relationship status may have impacted the relationships with their clients. Two clients, Scott and Logan, also commented on the ways in which this difference impacted the therapy relationship. Kara reflected on this and said, "Do I think it's impacted her therapy? I'm not positive, but it could. Sometimes, I think, because people have out and out said this to me before that people think I don't value marriage because I'm not married." She went on to say, "I had somebody say to me once that she thought I was incapable of being in a committed relationship." When speaking about her client in this study, Kara said, "She may be less comfortable due to the fact that I'm not married . . . I

hope not, but I don't know . . . I don't even know if she knows I'm divorced. I think she does … well, I don't know what she knows about that, to tell you the truth."

Dinah spoke about her process of trying to understand her client's experience around this important difference in their relationship. She stated, "I sometimes really don't get it, how lonesome his future looks to him. And I try really hard, and I don't have that experience." She continued to say, "He's really got mixed hope about that. He's been pretty hopeless about that sometimes. And so I listen, and I try to understand, and I really have trouble getting him sometimes. I try real hard, and I care."

In speaking about the difference in relationship orientation with her client, Selina commented, "This is the part that I'm, like, 'Oh, too bad I don't get to listen to what he has to say!' Because I'd be curious about how much this has come across in our relationship." She went on to admit some struggles in understanding her client's worldview regarding this issue, stating, "I think that's a part of our work, but I know that it has challenged me, in terms of, like, you know, 'Try to hold your biases and think outside the box,' you know? And so I've really, kind of, had to be, like, 'You have to help me understand how this works.'" Selina explained her experience of this dynamic in the therapy relationship:

> [I] really try to honor and understand, you know? Help this person find what's gonna be the best balance, and a lot of it's also about learning, you know? I've had to ask questions that I'm, like, "Uh, well, this is gonna show how little I know about this, but, like…" You know, so I've had to ask him, "Okay, so why is this a problem if, you know, this is a polyamorous relationship? Where's the problem? Help me understand it." And he's really talking a lot about, like, "Ah, 'cause we broke the rules," or, "We broke the agreement," or whatever. And so I've learned a lot, but I think that's a part that in ways in which we're different that has been a challenge for me because I know less. And so I try to read up and try to understand, really . . . I don't know, there's just nothing in my life experience that I can relate, even find that connection, you know?

The two clients, Logan and Scott, who commented on the impact of this difference, had very different experiences. Logan reported seeing this difference as a positive aspect of his therapy relationship. He expressed a view of his therapist as a sort of mentor in this area stating, "I really appreciate the fact that he has the experience of knowing what a real, long-term relationship takes to make it work out and what it looks like and can help me to change my perspective or be like, 'That's not marriage behavior.'" Logan went on to say he appreciates that his therapist "can prepare me for a step in life that I haven't taken yet."

Scott spoke about the challenge this created for him in feeling understood. He said, "I would talk about how much I wanted to get married, have a family. And she would always go, 'Well, there's benefits to not,' and stuff like that. And it was frustrating for me, because I felt like she wasn't really listening to me." Scott continued to express his feelings about this:

> Having family is a strong desire of mine, and, you know, staying faithful was a strong desire, and so I don't think she quite understood how, I guess, lonely…and how much I wanted that type of relationship. So there was conflict there because she kept trying to tell me, "You know it's not going to be happily ever after." I could try and express to her, you know, "I understand that." I have five older siblings that are married, I've seen it, and then my parents' marriage was awful, and so I see that, but I also see obviously there's pros and cons to everything, but I guess I saw way more pros. And that was frustrating for me, so that was probably the biggest thing that caused conflict out of those. So I don't think, I mean that's one thing I feel like…I don't think she quite gets. And then also, unless you're in that situation, you can say, "You know, I would do these things, or these things would be helpful." But if you're in that situation, those decisions become so much more difficult to make. And so, this isn't like, you know, "Should I go buy a car?" This is pretty big.

Personality Style

Five participants identified personality style as a meaningful difference in their therapy relationship. It should be noted that the descriptor "personality style" in this context does not refer to any strict established scientific definition of personality or personality traits as found in the research literature in psychology. In this section, participants' individual definitions of personality styles and personality traits, which were broadly conceptualized and at times contradictory, were used to identify this subtheme. In describing this difference, some participants referred to personality traits they perceived in themselves and their therapy partners such as being more organized or a tendency toward addiction. Some participants also described differences in basic worldview, thought processes, and temperament or explanatory style, such as optimism vs. pessimism as personality styles.

Awareness of Personality Style

Although many participants referred to stylistic variations or subtle differences in perception of the world between them and their therapy partners, only two therapists and three clients in this study identified personality style as a meaningful difference. Both members of one therapy pair identified this as an important difference between them. Therapists and clients who mentioned this difference seemed to regard it as quite important and on par with other demographic differences more traditionally discussed in research, such as gender and race/ethnicity.

The two therapists who identified this difference in their therapy relationships specifically noted addictive behavior, optimism, psychological personality type, and

transactional role as ways of differing with their clients. In describing how she differs from her client, Diana stated, "His tendency or propensity toward addictive behavior is also a difference between the two of us. I've been fortunate that way. I haven't had to struggle with that." She also mentioned, "There is an optimism that he has that I don't have--an approach to life. He believes that things will turn out right."

Helena, in talking about her client, said, "I would have to say we're pretty different people." She went on to explain this in terms of personality types as well as a Transactional Analysis (TA) model of behavioral roles. Helena said, "I am much more of a type A kind of person. [My client] is absolutely type B artist." She explained, "I tend to be fairly calm, and organized . . . She is completely an artist, she thinks like an artist; she organizes her life like an artist… She's incredibly creative, and that would not be how I would describe myself. I would describe myself as very steadfast, methodical." Helena also stated that her client spends a lot of time shifting between taking on the TA role of a "very judgmental parent" and a "very helpless child." Helena further remarked, "I think one of the biggest differences between us is that I feel like I spend the majority of my time, at least hopefully (I hope that other people would say that, too), in kind of that adult functional space."

The three clients who identified personality style as a difference described various ways of thinking and characteristics they saw in their therapists but not in themselves. Donald noted that his therapist "tends to look toward the positive, and I'm always looking at the negatives." He mentioned this difference a number of times during the interview stating, "It's a really important one." Jean described her therapist as being "much more confident in her decisions" and "much better at making boundaries." Henry

described his therapist as having a different "energy" and way of being. He commented, "She has just this very calm, I would say motherly, energy that is not something that I have. I don't feel like I have that quality at all. I want to be a parent, for sure. But I just don't have that same energy that she puts out." He also talked about his therapist as having a different "gendered characteristic." He described the difference in the following way:

> There's a difference there in terms of . . . the energy we have . . . [My therapist is] this strong, fierce independent woman, who is at the same time . . . motherly and nurturing, and, like, just so caring and compassionate . . . She can call somebody on their shit in a really gentle way. She can say, "You're being a racist asshole right now!" in, like, this really caring way. Like, "Examine your privilege damnit!" Say that stuff without it coming across, like, I can't say stuff like that. I'll just end up more, like, cussing at somebody, calling them a shithead instead of putting it nicely or finding other words. She's very tactful with her words, but also direct, gets the point across. I appreciate that. There's a difference for you.

Impact of Personality Style on Personal Identity

Both of the therapists and one client who identified personality style as a difference spoke to the impact of this difference on their personal identity. Diana, who pointed out the difference in point of view with her client, explained, "I'm more of a planner for the worst disaster, and then I think I can cope with it if it happens, so then I'm okay. That's how I manage my anxiety, whereas he manages his with really faith and optimism that I admire, but I don't have." When asked if her self-described "type A" personality was an asset in terms of her career as a psychologist, Helena laughed and replied, "It has helped!"

Donald, who identified his therapist as an optimist as opposed to his more pessimistic outlook, explained, "That also may be my profession." He shared a joke about his profession, saying that someone in his particular scientific field "spends his whole career trying not to screw up really badly . . . that's what we do. We want to produce results but not screw up badly. Our theoretical colleagues, well, you know, if they get one thing right, they're famous." Donald continued to discuss how his pessimism impacts his life:

> So, by nature, I concentrate on negatives, and perhaps also by training, because we're told to look for every flaw there is . . . Some of it is, um, I'm also not the most positive guy. I'm usually the, in any experimental collaboration, I'm the designated pessimist. Um, it actually helps. Because, number 1, you're rarely, you're actually very often pleasantly surprised and you're rarely unpleasantly surprised. And number 2, um, being a pessimist, it helps the job. So, it actually makes me a good debugger. If a problem, try and see into the heart of any given problem, and try to come up with a solution quickly. I'm good at that. And that goes with the negative. It's a strength to me professionally, but in the long term career, it's a bad thing; in my life, it's not particularly a good thing.

Impact of Personality Style on Therapy Relationship

Only two therapists and two clients mentioned how this difference in personality style has impacted their therapy relationship. Diana commented on how this difference affects her understanding of her client's worldview and his goals as a part of the therapy process, highlighting the distinction "in terms of what he wants versus what I want for myself." Helena remarked on the personality difference in terms of her role as the therapist in the relationship. She described spending time in therapy talking about whether her client is "able to stay in her adult space, or is she acting as a judgmental parent . . . or is she acting as a helpless child at this time? And I have seen one of my

major roles over the years is trying to help her stay in more of an adult kind of space, and functioning."

Jean mentioned the difference in confidence between her and her therapist, stating, "If I say, 'You're always so sure of yourself,' she'll say, 'I've been in therapy forever.' You know, so one of the things I love about her is she doesn't . . . it's not a very nice term, she doesn't ever lord it over you that she is so knowledgeable." Donald explained how the optimism/pessimism difference has played out in his therapy relationship. In describing his therapist, he remarked, "He's very positive, and so he always steers me to the positive side of things." He shared an example of this dynamic in the following story:

> As an example, he and I had a discussion on hobby activities. I was complaining that it's really hard to find time with a three year old. It's getting easier now, but for the last couple of years really hard to find time. And he says, "Well, you really gotta try, you really have to." And so I came in one day and said, "I'm sorry, in the last two weeks I just did not, was unable to find time to do a hobby." And he'd say, "Well look, the fact that you tried is a positive thing." And I'm here saying, "Sorry I failed." And he's saying, "No, no, no, don't see it as a failure." And so that's the kind of difference. And I guess in a sense that difference is also very essential to the relationship because he's providing some impetus I can't provide myself.

Life Experiences and Trauma

Six of the therapists in the study identified life experiences including trauma as significant differences between them and their clients. This area of difference is defined broadly and encompasses family of origin issues and childhood history, lifestyle, and traumatic experiences. It is worth noting that no clients identified this as a meaningful

difference, which is likely due to the limited knowledge clients have of their therapists' personal histories and lifestyles outside the therapy setting.

Awareness of Life Experiences and Trauma

Four therapists mentioned differences in family of origin or family culture. Although these differences in family experience were listed separately, there seemed to be quite a bit of overlap with other dimensions of identity such as race/ethnicity and SES. Barbara mentioned her client's family history and how it shaped his life when his parents had to leave their native country and come to the United States. She said, "For example, his mother, who is quite educated, having to work at a fast food restaurant, sort of his feeling about that loss of, kind of, dignity and respect that she underwent." Barry said of his client, "This client has a kind of a complicated family history that's intertwined with his ethnic/cultural heritage, and it took me a while to get that, or to even get the basic understanding of that." Helena spoke about her clients' lack of family support, stating, "I think a lot of the differences between us have come out of her life experiences, and really not having somebody who could help her deal with those issues early on, so that she actually could grow up." She continued, "And that's something very different than my own life experiences. So I do think life experience has made us quite different."

Two therapists noted their clients' trauma histories as important life experiences in which they differed. Helena commented that her client had experienced a physically abusive significant relationship, and that she herself had no personal experience with that type of relationship. She also mentioned that her client was born "facially disfigured" and required "multiple surgeries as a young child." Helen stated, "That certainly is

something that I have never dealt with in my own life." Bruce, whose client is a veteran, discussed trauma as a particularly important part of his client's history. He mentioned having personally experienced traumatic situations in his life, but highlighted his client's experience of military combat as a unique difference between them:

> I've been around enough veterans to know that that creates a difference between me and that person. And even if I don't perceive it, they do. And veterans frequently comment on – they feel very disconnected from everyone around them because most people who have not been there, cannot even begin to imagine the horror and the confusion and the combination of fatigue and fear and anger, and wanting to kill at the same time not wanting anybody hurt. It creates a difference; it's a whole new culture of itself.

Finally, one therapist, Donna, mentioned her client's lifestyle as a meaningful difference, particularly his love of hunting. For her, this was a significant difference in relating to the natural world. She said that he brought this up in therapy, "and I remember just thinking, 'Oh my gosh…hunting!'" Donna reported that she had encouraged him to "do things that were good for his well being and he was like, 'Yeah, you know, I really want to go and get a big elk trophy head.'" She went on to explain, "And I'm just internally, like, 'Oh, my gosh!' But, you know, that was the biggest barrier. And I was, like, 'You know, it's part of something that he likes to do.' And plus he said that he's just going to be filming it. He's not going to actually be killing it."

Impact of Life Experiences and Trauma on Personal Identity

None of the six therapists discussed the personal impact of the differences in life experience they had with clients.

Impact of Life Experiences and Trauma on Therapy Relationship

Only four of the therapists who mentioned life experience commented on how this difference affected their therapy relationships. For two of them, it seemed to have a minimal impact. Donna, whose client enjoyed hunting, stated that, when this difference came up in session, she simply noted it, as well as her own reaction, and continued on with the discussion. She remarked, "I didn't say anything to him because it wouldn't have been therapeutic as an intervention." Barry, who noted his client's complex family history, said, "I don't know that it was a barrier, but if I would have gotten that sooner, it would have been better. I felt like it wasn't detrimental to the work; but, in retrospect, I wish I would have gotten that a little earlier."

Bruce, whose client had a history of combat trauma, reported that this experience was one of the most important differences between them. He stressed, "That one's always in my mind, and I always keep that present when I'm talking to someone who has experienced trauma that I don't know. And so I have to learn from them what their experience was." He went on to say, "Theirs is unique from every other veteran, maybe even the guy next to him, because they took a whole different load of experiences into that combat situation or trauma. And so I have to find out from them what it's like to be them in a traumatic situation." He explained that in his work with clients with combat trauma he attempts to understand "without pretending that I ever get it, because I don't. I can reflect and get a hint, a taste of what it was like, and I think that that feels really good for them because most people in their life don't do that, they don't even try and go there."

Helena briefly discussed the impact of her client's history of facial disfigurement on their therapy relationship. She identified this as being an important part of the work

with her client stating, “I do think that over the years there certainly has been a certain amount of re-parenting that has occurred in our relationship, and healing of some of those early wounds from being disfigured, and born disfigured.” Helena explained:

> That has helped her shore up her sense of self as an individual who can be an independent individual instead of dependent on people in her life; that she can stand on her own, I think, has been really important for her to keep coming back to it as a belief . . . and feeling like somebody cares about her consistently and that she has value in the world, has something to contribute to the world, and that she’s not defined as a person by her facial disfigurement.

Interestingly, though Helena’s client did not identify this as a meaningful difference in their relationship, she did make a comment about addressing it in therapy. She related that Helena said in session, “‘It’s true about people with cleft palates, that they always feel less because they can’t…because your face isn’t perfect . . . There’s a part of you that never feels like she can be that perfect child that her mother always wanted.’” The client continued to share her reaction to this saying, “And I thought, you know…well, and clearly I have. I think it used to be a self-esteem issue with me.”

Appearance

Two participants brought up appearance as a meaningful difference in their therapy relationship. They spoke of different aspects of appearance from physical traits to more cosmetic things.

Awareness of Appearance

One therapist and one client from two different pairs mentioned appearance. There was no pattern in terms of discussing one’s own appearance of that of the therapy

partner. Donna, a therapist with visible tattoos, talked about her own appearance and how it is different from her client, as well as many of her other clients. She said, "I mean – tattoos, the hair…I mean, this is who I am, though, and I feel really good as this. But then other people might see me . . . I mean sometimes I do get strange looks. And I guess appearance, too, is another area [of difference]." Logan linked appearance to gay culture, saying, "Appearance is a really important part of gay culture, and that's something that [my therapist] doesn't always understand . . . I do think that's maybe something about my therapist] that we have a little bit of a difference." He continues to say, "But that doesn't bother me at all. I am head over heels in love with this therapist. I would never stop liking him … but when it comes to appearance things, I know he's not going to quite get it; and I think he's also going to maybe negatively judge a little bit."

Impact of Appearance on Personal Identity

Donna described this appearance issue as another "facet of identity." She said, "I'm not quite sure what you would call that. Appearance, or maybe conservative/liberal kind of thing. I don't identify in therapy as liberal, but . . . I think my appearance shows that I'm pretty liberal." Donna went on to say that "certain clients feel very safe with me, seeing me, and probably others want to run shrieking out of the room, like, 'Who is this?'. . . I don't take it personally. But I realize that appearance says a lot."

Logan spoke about the difference in appearance and the role it played in his life as a gay man. He said, "I mean, I do think that it's a gay/straight thing, you know? I think you can be a straight dude who's sort of slovenly and you're still pretty sexy, you know? And I don't think it's as important to be hot when you're married and a straight guy." He

also explained some reasons why appearance and being fit is an important issue for him as a gay man, and why the cultural context must be taken into account:

> It's because of the way men are socialized to perceive bodies and that the weight of the male gaze and that sense of judgment is so intense that it causes women and gay men to constantly be conscientious of how they appear and their potential for dating really rests in their appearance. And in the gay world and in the straight world for women, beauty is power and a type of currency, and if you're unattractive and a gay man, you'll not date. You socially have a much more difficult time, which has a really large impact on your mental health and self-esteem.

Impact of Appearance on Therapy Relationship

Donna did not comment on how appearance may have impacted her relationship with the client in the study. Logan stated that appearance has come up once in the relationship with his therapist. He said that it emerged in the context of eating and fitness, where he had some concern that his therapist might have been pathologizing his behavior due to a lack of understanding. He said, "We talked about it the entire session, and then he told me that he thought I was sort of bordering on an eating disorder, and then I've never brought it up since, and neither has he . . . I feel like that's a pretty big difference between us that has caused us to not talk about it. Logan also stated, "And if I did get into a position where, like, I started taking diet pills or doing steroids or, you know, doing something really extreme, I don't know if I'd bring it up with him … I mean, I would, because I have such trust with him, anyway, but that's a difference."

<u>Language</u>

Two participants identified language as an important difference in their therapy relationship. Some of the comments regarding the language difference overlapped with

comments about race/ethnicity and culture in general. However, the issue of language as a difference and potential barrier seemed to play a large enough role to warrant a separate subtheme.

Awareness of Language

One therapist and one client from the same pair mentioned language as a critical area of difference in their relationship. Both participants were fluent in English and did not require an interpreter to conduct therapy. However, English was not the first language of this particular client. The therapist in this pair, Barbara, listed the language difference and stated, "I think we did pretty well together, but I really wish I could be doing the counseling in Spanish." The client, Pedro, expressed his awareness of this as a challenge in therapy, stating, "My main difficulty and challenge is the language, right, so sometimes I want to express something and I'm trying to find the word or trying to find the sentence, you know, the way to express something."

Impact of Language on Personal Identity

Barbara did not mention any direct impact this difference had on her personal identity, but rather commented on the impact it had on the therapy relationship. Pedro remarked on the difficulty he has sometimes had around expressing himself.

Impact of Language on Therapy Relationship

Both Barbara and Pedro recognized that the difference in first language between them had an impact on their therapy relationship and the process of therapy. Both also

commented on how diligently they tried to overcome this challenge. Barbara related, "I've talked to him about the language differences explicitly and just asked him when he has a phrase in Spanish, then he says, 'I don't know how you'd say it in English,' and I'll say, 'Well, tell me in Spanish.'" She recalled that, on one such instance, "He wrote out the words so I could, because I knew the words, actually, when he said them, but I guess I've often invited him to tell me about those things." Barbara also explained that she has tried to use this difference as an opportunity to be playful and create a more egalitarian relationship. She said, "I speak a tiny bit of Spanish and he speaks much better English . . . and he lets me throw in a little Spanish here and there." Barbara continued, "I think that's the playfulness that has been in our relationship, was at the end or sometimes when we're lightening up a little bit. Sometimes I'll say a little bit in Spanish or he'll, in that one case, teach me a little Spanish, and that's been kind of fun."

Pedro reported, "She pretty much understands everything that I say; and, if I see she doesn't, I will say it again or try to, you know, approach another way to say it. But mostly, she understands everything." He also demonstrated a heightened awareness of the possibility of miscommunication in the therapy relationship due to the language difference when he said, "It's challenging, because, especially when you're dealing with feelings, you just want to say what you really feel; and if you don't find the adjective, you know, or whatever describes what you feel, it can be frustrating sometimes." Pedro also said, "But there are ways, you know, to explain, to let them know what you feel. But I think that's a pretty good example of a challenge." He related a specific incident in which he felt that his therapist was getting the wrong message stating, "I felt like maybe the way I said stuff, I put myself as a victim, but I'm not, so I tried to rephrase everything

that I said and tried to put it, like, in a past perspective, but then at the end she got the message." Finally, Pedro explained his strategy for dealing with this difference in therapy:

> I know the difficulty and, you know, how hard it would be for somebody to understand a person that isn't a native in that language, I try to be very calm when I talk to her and don't get desperate when I just want to tell her everything, right? So I try to be really, really calm and speak slowly and try to pronounce well, you know, anything I have to say . . . I think it's a good exercise. It's kind of like exercising being patient and controlling your feelings, I guess.

Theme 1 under *Experience of Differences* explored the many areas or dimensions of difference that participants identified within each therapy relationship. Clients and therapists demonstrated varying levels of awareness of these differences, with therapists generally appearing to be more aware of them than clients. Participants discussed how these differences impacted their own identities as well as their therapy relationships. Some differences such as race/ethnicity and gender and gender identity seemed to resonate powerfully within certain relationships and impact the process of therapy in a significant way. Others, such as appearance, seemed to play a more minor role in the relationship. The next theme discusses participants' experience of differences as enhancing the therapy relationship.

Theme 2: Differences as Enhancing the Relationship

As discussed in the previous section, several cross-cultural differences that were identified between clients and therapists had a substantial impact on the relationship. Participants reported that some of these differences had profound impacts on relationship dynamics and, at times, represented key challenges that had to be overcome in order for

the relationship to strengthen and the therapy process to move forward. A number of participants, however, described the differences in their relationships as playing essential and positive roles in the therapy process. The second major theme to emerge from the *Experience of Differences* was *Differences as Enhancing the Relationship*.

This theme of differences as enhancing the relationship seemed to run through several therapy pairs; however, only one therapist and six clients explicitly addressed it. These participants directly labeled their differences as positive aspects of the therapy relationship and important components of the therapy process. Barbara, whose client differed from her in a few meaningful ways, spoke about their differences, stating, "I think in some ways it may have enhanced it, because I have to be, or I want to be, mindful and thoughtful of them. And I think it would be easy sometimes if someone was less obviously different than I am on so many variables." Donald reflected on this theme: "I guess, in a sense, that difference is also very essential to the relationship, because he's providing some impetus I can't provide myself." Steven, who noted some significant differences in life experience from his therapist, said, "I don't judge him, you know? He chose to go to school for what he's doing, and without guys like [him], guys like me wouldn't have somebody to talk to."

Henry and Logan both talked extensively about meaningful differences between them and their therapists. Each one shared that their differences were also important aspects of their work in therapy. Henry stated, "I guess I don't see any of our differences as, like, obstacles . . . I think our differences, if anything, enrich our interactions . . . I think those differences do affect our relationship. I would say more in a positive way than a negative way." He went on to say, "I think I appreciate that we have different

experiences of who we are in the world . . . the differences more than anything are what I love about my relationship with [my therapist], because she can see things that I can't. She has a perspective that I don't." Logan related his experience of the difference in sociopolitical status that went along with the differences between him and his therapist. He explained his perspective of differences as enhancing the therapy relationship:

> I think it's really therapeutic, probably for anyone of a minority status, to work with a therapist who's of a majority status and to feel truly accepted. It's kind of a symbolic reconciliation with power, you know? . . . and to have a straight, White guy, or a straight guy in general, you know, give me that acceptance is a really unique experience. I mean, it's great. It gives me an additional sense of acceptance to myself that this can't be all as bad as I sometimes I think it is.

Theme 3: Building on Common Ground

The third major theme to emerge under *Experience of Differences* in the 26 interviews conducted for this study was *Building on Common Ground*. This overall theme reflected the apparent desire of participants to focus on things they perceived to have in common with their therapy partners rather than differences, which many—either implicitly or explicitly—be interpreted as inherently negative or potentially threatening to the relationship. Within this theme, there also seemed to be a strong urge among participants to identify with their therapy partners in some way. Some demonstrated what felt like a need to stress their sameness as a means of highlighting or reaffirming their close connection.

Overall, therapists and clients in this study demonstrated a tendency to focus on similarities and discount or minimize the impact of differences between them. Despite the numerous references to differences in the recruitment materials, informed consent

document, and the verbal explanation of the study, most participants seemed to want to discuss ways in which they perceived themselves to be similar to their therapy partners. Arthur seemed to have thought about this question for some time before our interview; and, yet, his response was as follows:

> I knew you were going to ask me about this, and it's kind of a hard question for me to answer, actually, because in a lot of ways I don't feel that different… um… I see him as a colleague would be the best way of putting it. Granted, someone who's a few years behind me, but still a colleague, you know. And I mean, obviously, there are differences in sexual orientation, and we have differences in upbringing. He was raised LDS in Utah, and I was raised in Utah but not LDS, so we have those differences. But they…I have trouble seeing how those differences really impact us, or impact the work that we do together.

Participants often listed similarities alongside differences and emphasized shared interests, traits, and beliefs. The following quote from Barry is a good example of the typical similarity-focused interview response when asked about the ways in which he differed from his client:

> Yeah, that's a good question. And I'm just thinking about sexual orientation; I identify as straight or heterosexual and I think this client does, as well, as far as I know. And of course, that's on a continuum and uh, I don't know exactly where we would fall relative to each other on that continuum, but I think we're similar in that way. Um, any other differences… My sense is that this client is kind of not religious, at least in terms of organized religiosity, and that is also true for me. So, I think we're similar in that way. I'm just going down a checklist in my mind to see if we're different in any other way. Yeah, you know, I think we're both reasonably able-bodied . . .

Some participants discussed finding and using similarities as a way of building the therapy relationship and establishing trust. Roberto, a client who was initially tentative regarding the racial difference with his therapist noted, "You build on that, you build on what connects you. I mean, I did with him anyways . . . So there was like a part of my issues that he understood." Before speaking about differences with her client,

Selina said, “So this might go around your question a little, and then get to it. But I just want to talk about . . . some of the similarities that I feel like we have . . . I think that connecting from that perspective has allowed us to talk about some of the differences.” Kara explained her perspective on similarities and connecting. She stated, “The human conditions are pretty common. Now that might not go with your diversity study, but I think there’s more we share than we differ in, by far; and I think there are only a few common human experiences, and we can all connect to each one of those.”

Several therapists and clients listed similarities or things they perceived to have in common with one another as more important than the ways in which they differed. Many of these participants spontaneously identified individual areas of similarity and discussed their impact on the therapy relationship in much the same way they commented on differences.

Selina, Hal, and Roberto emphasized the impact of having the same gender or gender experience as their clients. Selina mentioned the importance of being able to talk about “what it means to be female in our society” with her client. She went on to say that they discussed “societal expectations, and gender norms, and gender experiences that we have as a female versus male. And how people respond to you and expect different things from us simply because of being a different gender.” In discussing the relationship with his client, Hal commented, “I think we’re both male and I think that there’s kind of a masculinity piece associated with this where he feels comfortable with me enough.” Hal talked about their shared experience of at one time “embracing rigid masculinity and then shifting away from that.” He explained, “I think we were both given some lessons in masculinity and endorsed them at times and now have moved away from them.” In

talking about the main issues dealt with in therapy, Roberto stated, “I will have to say that definitely the fact that he was a male really facilitated that discussion.”

Hal also noted a similarity in gender identity development that he and his client shared. He said that his client had “a pretty advanced understanding of his own gender socialization, so I wasn’t faced with what I typically experience with men who are sort of underdeveloped in that understanding . . . they tend to feel me as a threat or try to compete with me. Hal stated that many male clients come with a thought of “I shouldn’t open up, particularly to men, and show my weakness.” He explained that masculinity and their shared understanding of masculinity was a key element in the therapy relationship, stating, “I think there definitely was always this sort of thing that held us together on some common kind of a platform. Much more than like this - we’re both higher education kind of, same college kind of thing . . . It was very much more the masculinity.”

Some areas of similarity discussed by participants were not as common but played just as powerful a role in the therapy relationship. One therapist mentioned childhood SES as an area of similarity. Selina stated, “I didn’t mention socio-economic status as a difference, because, even though there is a difference in terms of where’s he’s at in his life, I think that his upbringing and my upbringing in terms of socio-economic status were similar.” Henry, who identified as queer, speculated that his therapist saw the world in a similar way. He remarked, “I haven’t asked [my therapist] if she identifies as queer necessarily, but I think [she] is pretty queer too. Just in terms of how she looks at the world, you know? The choices she makes, that I see, at least, the ones that are visible.”

For a few participants, this emphasis on similarities manifested in discussions about shared interests. Kara mentioned on two occasions during the interview that she and her client "both like to cook a lot!" When describing the relationship with his therapist, one of the first things Scott said was, "We both like running, so we usually talk about running." Janet pointed out, "We have a lot of things in common. We both like to bake. We talk a lot about cooking. Like when I first get here, we'll chat for a minute about that or she'll tell me about her grandkids . . . You know, we've exchanged recipes!"

Parenting was another area of similarity where participants found connections. Roberto talked about him and his therapist being of the same gender, then remarked, "So it was not just that he was a man, or a male, it was that he was a father. So there was like a part of my issues that he understood. You know, so, but, I will have to say that definitely the fact that he was a male really facilitated that discussion." Kara mentioned, "I think one place we connect really well, and that's what she says, is we're both mothers; and, for both of us, that's probably the most important thing we've ever done in our lives. She said, "And I think she knows how strongly I feel about it, and I know how strongly she feels about it, and I think it's something that we connect well on." Donald, who identified race and family background as important differences in his therapy relationship, pointed out that he and his therapist were both married with children and stated, "We have just such a similar background, it's, um, it's sort of almost unnatural."

Donald also commented on similarities in upbringing that were discussed between him and his therapist, even though they came from very different cultures. He summarized it in this way:

> And [my therapist] tells me that he was, at least, uh, raised Mormon, and we never discuss his current religious affiliation, but that he sort of

> confided, it's not really a confidence, but he made the comment that having a Mormon mother is not that different from having a Chinese mother (laughing). And so, we even have that, even though there's not complete empathy, but there's some similarities . . . the guilt business. My mother was very good at guilting me and apparently his mother was very good at guilt, too!

Participants in a number of the therapy pairs identified as members of the same religion. Some of these therapists and clients reported their shared belief system was an important similarity on which to build greater understanding. Clark commented on the common faith he shared with his client, saying, "We have the Church in common, and this woman's a returned missionary, and Church is very important to her . . . You know, there's a commonality and understanding, understanding of jargon and everything else that is automatic." He continued, "I know that was true for her, because her faith is really important to her; and, so, the discussion of that really made a difference in terms of trust and understanding between us, so . . . and introducing it even into the process . . . I think that was pretty useful." Warren, who stated that he did not feel his therapy relationship was very personal, also mentioned this similarity of religion with his therapist. He stated, "I mean it was nice. Just the fact that . . . there's a lot that I don't have to explain about where I go to school and stuff like that. And so it was nice having a lot of similarities." Natasha reported the similarity in religion with her therapist was one of the most important aspects of therapy for her. She even remarked that she did not seek counseling at another agency for fear of seeing a therapist who did not respect and understand her religious beliefs.

Dinah commented on sharing the same religious affiliation with her client. She spoke about the benefits of having a common understanding. Dinah said, "I know a lot by observation and by experience about what it can mean to a person who's devout in a

unique, kind of quirky, different than the world, minority religion . . . with very, very different attitudes about sexuality." She went on to say, "I also have a view of what it would be like to be devout and have an orientation that's not well understood and not welcomed as much as I wish it could be." Dinah also remarked that the more important similarity might be devoutness as opposed to having the exact same religious faith, "I think what would be helpful for a devout person to know that another person is devout, and then to have respect for their devoutness." She stated that sometimes being of the same religion can be counterproductive in therapy, "as in the case when people have such different takes on it. And the reason is what they're coming into therapy for. Sometimes it works well, and sometimes it doesn't."

Scott mentioned religion as a primary identity in his life and one that was also a source of conflict for him. He stressed the similarity in religion with his therapist and the shared understanding they both seemed to have:

> I think it's helpful in the fact that she can see the conflict. And I think, for me, it's more helpful than I feel like it would be for someone else, maybe. For me, it's helpful, because even before I saw [my therapist], I had a different view of the church than I feel like a lot of other people did. And then, also, I guess, I'm not afraid to challenge church doctrine or teachings--what people say. So I don't know…for me, it's helpful because…it helps her understand the conflict I have. Whereas I feel like if it was someone who wasn't LDS, they would be like, "Well just leave the church." So she can understand this conflict that I have about leaving the church. So that's very helpful . . . Yeah, that's a better way to say it – appreciating the role that it plays in my life.

Even in pairs where the therapist and client were not of the same faith, there appeared to be a desire on the part of clients to find connection in this area. Anthony, who identified religion as a clear difference in his therapy relationship, said of his therapist, "I think she believes some of the things I believe. I don't know that for sure; I just get that sense."

Steven, who acknowledged some difference in religion with his therapist, was quick to say that they were both "Christian." Janet also pointed out the fact that her therapist did not share her strong religious beliefs, stressing, "The core values that we have are similar . . . I think, in that way, we're a lot alike."

A few participants identified similarities in education, field of study, or career as having a significant impact on the therapy relationship. Barry stated, "We're similar in that we're both educated. He has a Ph.D. in his field. And of course, as a psychologist, I'm a PhD in my field." Selina noted her client's education saying, "His degree is so very much into [the] psychology, social advocacy kind of area, and was helpful because we were able to talk a lot about power and privilege."

Arthur spoke about the unique similarity he shared with his client and how it impacted their relationship in the following quote:

> Well, I feel, actually, we have a very strong relationship. In fact, I would say it's one of the strongest out of all of the clients that I see. I think part of that is because he's a therapist in training, so there's kind of an extra bond around that. And so we do talk about that stuff a little bit, we're able to talk about the process of what's going on between the two of us, but I think that we also, just, we connect pretty well . . . And I would say also just the way that we think about things, there seems to be some similarities there, just in terms of being thoughtful about things. And I think perhaps being open to things, like I just feel like there's a kind of unspoken connection on that, on that wavelength. Like it feels comfortable to talk about things, kind of deeper things, that isn't just about…that isn't just because we're doing therapy, you know? I mean if I think about it, I'm probably more….not probably…I do disclose more to him about me, personally, than I do with other clients. Again, part of that is due to the fact that he's a therapist himself. But another part of it is the connection.

For clients, this similarity in education, field of study, and career track seemed to be quite powerful. Donald stated, "We were both in academia, and we both supervise students and graduate students; and so, that commonality of that background, even

though in different disciplines, it makes it very easy for me to understand what he's telling me." He also said, "It probably makes it easier for him to understand where I'm coming from at any given moment. So, there, we pretty much get right to the point without having to guess, doing much guesswork." Logan pointed out, "I also like that he's current on men and masculinity research, and I appreciate that he approaches me from a qualitative feminist [perspective]." He also mentioned the shared educational experience with his therapist. "We're from the same program. I mean, I don't know if our therapy would be as effective if he wasn't as familiar with the process I'm going through and the personalities. Yeah. That's helpful."

Henry and Roberto both identified professional interests they shared with their therapists. Each commented on the importance of the similarity in worldview these shared interests seemed to bring. Henry said, "I see us both as activists, in a way. I think that [my therapist] is an activist through therapy, through being a therapist, which is a really unique, really intimate way of being an activist. And really powerful." He went on to say, "I don't know that [my therapist] has directly changed any of my opinions or thoughts about the world, but I love examining issues of justice with her." Roberto stressed the meaning behind his therapist "understanding my research." He said, "He didn't just tell me, 'Oh, I understand critical race theory.' He said, 'How has putting race up in front of your research affected [it]? Did you do it because that's kind of like the way you live, you know, where you see race all the time?'" Roberto continued, "So he was not just knowledgeable about the research, he was able to apply it . . . So he was already able to understand many critical race theorist approaches . . . So I think that that, along with understanding the approach from a feminist standpoint also."

A perceived similarity in age was noted by some therapists and clients. Barry observed, "As it happens, we are approximately the same age. Now that I say that, I think of us being the same age, I'm probably 8 or 9 years older than he is. But I guess you could say we're both men of a certain age. And we're in somewhat similar phases of our lives." Hal noted, "Since I'm newly out of graduate school, there's this generational understanding that I kind of have, so that piece I like, just in general working with graduate students." Steven speculated that he and his therapist were quite close in age and described the "younger approach" used in therapy. Donald mentioned the "proximity of age" between him and his therapist. And Logan said of his therapist, "He's not that much older than I am, which helps."

Clients and therapists identified several dimensions of difference they perceived as meaningful in their therapy pairs and how these differences impacted their relationships. They also discussed important similarities that occurred in the relationships and how these areas of common ground helped to develop stronger connections. The ways in which differences were addressed in the relationships seemed to vary at times; but, overall, therapists appeared to take responsibility for initiating the discussion. This dynamic is explored in the final theme, *Power and Responsibility*.

Theme 4: Power and Responsibility

The fourth and final theme under the *Experience of Differences* was *Power and Responsibility*. This theme addressed the power dynamics involved in dealing with differences within the therapy relationship. The majority of the therapists in the study reported that they typically address differences in the relationship, especially obvious

differences of which they are aware, in a direct manner. Even those therapists who were not quite as direct in their approach endorsed the importance of naming or opening the door to discuss any potential source of misunderstanding or conflict. Some, like Kara, simply said, "I think I generally just bring it up to them, this is what it is, are you okay with that?" Other therapists, such as Arthur, discussed dealing with differences as a part of connecting with his clients. He stated, "If I don't feel like I'm connecting with a client, I'm going to figure out what it is that's in the way of that, and . . . I'm going to go after that, and figure out what is it that's missing. But typically I address those things if I feel like they need to be addressed." Diana explained her approach to addressing differences:

> What I try to keep in mind is anything I don't understand, to kind of pursue with some line of questioning so that I can understand. So some of those are big differences, like religious differences, or some of those are more subtle things, like how you spent that part of your day or something, so I think that's kind of my philosophy, you know, is to come up with hypotheses about what's going on; but, in order to do that, I need to have information, and then I need to check out my hypotheses.

Most therapists in this study endorsed a belief that it is the responsibility of therapists to address differences in the therapeutic relationship. These therapists indicated that this responsibility lies with therapists due to the inherent position of power in the relationship, especially when the therapist is of a majority or privileged status and the client is a member of a historically disempowered or oppressed group. Clark commented on his view that the therapist is responsible to address differences "because there's a power differential between therapist and client, and therapists are supposed to know the rules of the game." He said, "You know, maybe, if it's a client with some experience in therapy, they might be able to do that, but I really put the responsibility

pretty solidly on the therapist's shoulders." Hal expressed a similar point about this responsibility when he said, "I have power as their therapist, whom [clients] may perceive as someone who's an expert or going to diagnose [them] or someone who's going to tell [them] what's wrong with [them], so even though that's not what I do, that may be the perception of me." He continued, "So I have this power; and, to the extent I don't name it, they may think I'm pathologizing them, operating from this culturally encapsulated lens, that I don't feel like I do."

This theme was also expressed by therapists representing a wide range of theoretical orientations. Barry, who identified himself as drawing from a number of theories, but primarily a Humanistic-Existential therapist, stated, "I certainly feel that responsibility. And even though I try to share power, I still share that responsibility. And I do believe that therapists are more responsible to raise those issues, certainly, with clients." Barbara, a more psychodynamically oriented therapist, spoke about being influenced by multicultural researchers Donelda Cook and Janet Helms, saying, "[They] talked and others have talked about the person with sort of a more powerful role in the dyad, trying to make it safe to talk about things." She went on to say, "So I try to usually at least say something [regarding] my own perspective or membership in the privileged group, I guess just so that I would hope the client feels like it's safe to talk . . . I hope it comes across as an invitation and a sense of safety."

The extent to which therapists regarded the explicit acknowledgement and discussion of differences in the relationship to be their responsibility seemed to have a great impact on how differences were addressed in the each therapy relationship. It is quite likely that this theme may have played a significant role in influencing and shaping

each participant's experience of differences in their particular relationship. This is discussed further in Chapter 4.

Conclusion

The results of the 26 participant interviews representing 13 distinct client/therapist pairs with one or more cross-cultural difference yielded two areas of phenomenological description with several themes and subthemes discussed in Part I and Part II of this chapter. These two areas were based on the primary research questions that guided this study. The first research question, *How do clients and therapists in a cross-cultural relationship (where client and therapist differ by race/ethnicity, gender, sexual orientation, religion, or other salient variables) perceive and experience the therapeutic relationship?* was addressed in Chapter 3, Part I, *Experience of the Relationship*. The second research question, *How do these clients and therapists understand and make meaning of the impact of their cross-cultural differences on the therapeutic relationship?* was addressed in Chapter 3, Part II, *Experience of Differences*.

Part I, *Experience of Relationship*, described the lived experience of the therapeutic relationship from the initial referral process and development of the trust to the various factors influencing the relationship dynamic, as related to me by both clients and therapists interviewed for this study. In this part, four major subthemes were identified from participant interviews: *Referral and Initial Impressions, Development of Therapeutic Relationship, Shared Investment,* and *Emotional Connection*. The perspectives of both clients and therapists were discussed within each theme. The first major theme in Part I, *Referral and Initial Impressions*, yielded three subthemes: *Referral*

Process, *Previous Encounters and Therapy History*, and *Initial Impressions*. Under the second major theme, *Development of Therapeutic Relationship,* four subthemes emerged: *Building Trust, Understanding Worldview, Balance of Power*, and *Positive Change*. The third major theme, *Shared Investment,* contained two subthemes: *Therapist Investment in the Process* and *Client Investment in the Process*. Analysis of the fourth major theme yielded three subthemes: *Caring Relationships, Positive Perspective,* and *Liking Who I Work With*.

Part II of Chapter 3, *Experience of Differences,* dealt with the phenomenological experience of meaningful differences between clients and therapists in the same therapy pair. In this part, four main themes brought out from participant interviews were discussed: *Dimensions of Identity, Differences as Enhancing the Relationship, Building on Common Ground*, and *Power and Responsibility*. Within the main theme, *Dimensions of Identity,* 13 subthemes emerged, representing differences identified by clients and therapists: *Race/Ethnicity, Age and Experience, Gender, Relationship Status, Religion, Socioeconomic Status, Sexual Orientation, Personality, Life Experiences, Trauma, Appearance, Language, Gender Identity*, and *Relationship Orientation*. Under each of these 13 subthemes, three additional subthemes were discussed: *Awareness of the Difference, Impact on Personal Identity,* and *Impact on Relationship*.

Throughout this chapter the lived experiences of clients and therapists engaged in cross-cultural therapeutic relationships were described using their own words whenever possible. In sharing their experiences, participants in this study identified those factors that contributed to developing and strengthening their therapeutic relationships, including past experiences, initial expectations, behaviors and attitudes that facilitated trust, a sense

of mutual commitment, and sincere emotional connection. Clients and therapists also described their experience of cross-cultural differences in the therapeutic relationship, including their awareness of differences, how they impacted personal identity and the therapy relationship, similarities in their relationships, and the intersection of power and identities in the relationship. The meaning of these results will be discussed further in the context of previous research in Chapter 4 along with limitations to this study as well as implications for future research, practice, training, and social justice.

CHAPTER 4

DISCUSSION

"The most precious gift we can offer others is our presence" (Nhat Hanh, 1975, p. 23).

The purpose of this study was to gain an understanding of both client and therapist experiences of cross-cultural differences in a therapeutic relationship. The preceding chapter highlighted the results of the study, which included 26 participant interviews focused on two main areas of inquiry. These areas of inquiry were represented by Part I, *Experience of Relationship,* and Part II, *Experience of Differences*. During the analysis of the data, eight major themes emerged, with four themes in Part I: *Referral and Initial Impressions, Development of Therapeutic Relationship, Shared Investment,* and *Emotional Connection*; four themes in Part II: *Dimensions of Identity, Differences as Enhancing the Relationship, Building on Common Ground,* and *Power and Responsibility*; and several important subthemes. This chapter will summarize the findings; discuss limitations of the study; outline implications for practice, social justice, and training; and offer suggestions for future research on cross-cultural psychotherapy relationships.

The results of this study revealed a number of important findings, including some that corroborated previous research and others representing new insights and greater depth of understanding into psychotherapy relationships and cross-cultural therapy.

Horvath and Bedi (2002) described the positive bonds of respect, mutual trust, caring, and liking one another as essential elements of the therapeutic relationship, along with goal consensus, mutual commitment to the process of therapy, and belief in the commitment of one another as key elements of the therapeutic alliance. In Part I of the current study, clients and therapists identified a number of important factors that contributed to the development and strengthening of the therapeutic relationship, that correspond to these findings. These correlating factors included initial expectations based on previous experience, behaviors and attitudes that facilitate trust and positive connections, a sense of mutual commitment to the therapy process, and sincere emotional involvement.

Part II focused on the experience of differences in the therapeutic relationship, including the ways in which differences are addressed, the impact of differences on personal identity and the therapy relationship, the tendency of therapy partners to focus on similarities over differences, and the intersection of power and differences in the relationship. These findings are also consistent with the assertion made by Horvath and Bedi (2002) that, regardless of what each individual brings to the psychotherapy encounter, it is how he or she interacts and the relationship that is formed that is paramount.

Research has shown the client/therapist relationship to be the most influential variable in terms of psychotherapy outcome, with three to five times the amount of change attributed to the relationship than to specific therapy techniques (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011; Wampold, 2001). This study confirmed these findings as client participants overwhelmingly

associated the positive and transformative effects of their experiences in therapy to the meaningful therapeutic relationship shared with their therapists regardless of cross-cultural differences. Clients in this study placed greater importance on the connection they felt with their therapists than on any specific set of techniques employed in therapy. In fact, when asked to identify what was most helpful about their psychotherapy experiences, most clients described a characteristic of the relationship or the way they were treated by their therapist. This supports Metcalf, Thomas, Duncan, Miller and Hubble (1996), who found that clients attributed positive outcomes to relationship factors. Very few clients mentioned theory-driven interventions, and those that did attributed the effectiveness of the interventions to their therapists' skill.

In the first major theme, *Referral and Initial Impressions*, client participants reported that the circumstances of their referral and prior therapy experiences can have a significant impact on their initial attitude and expectations regarding therapy. A direct referral or recommendation from a trusted source (friend, supervisor, previous therapist) contributed quite a bit to forming positive expectations for therapy in the clients in this study. This is consistent with prior research on therapy outcomes stating that extratherapeutic factors, or those independent traits and experiences brought by clients to therapy, account for about 40% of outcome, and client expectancy accounts for roughly 15% of improvement in psychotherapy clients (Lambert & Barley, 2002).

In contrast, results of this study also revealed that, although prior negative therapy experiences may influence expectations and foster a more hesitant or guarded approach in some, this did not prevent the development of trust and positive working relationships with new therapists. In fact, for the few clients who disclosed prior negative experiences,

there was a sense of emerging assertiveness that seemed to enable them to be more proactive in verbalizing their therapy goals and preferences. It may be that, for some clients, the hope for a close, trusting relationship and a desire to connect with another person in a meaningful way outweighs the fear of reliving another disappointing experience. It may also be that the acute level of distress and hope for symptom relief expressed by a number of clients motivated them to engage in therapy again despite negative past experiences. This is consistent with previous findings emphasizing the importance of client hope and expectancy (Wampold, 2007).

This study also found that a critical aspect in the initial development of the therapeutic relationship is clients' willingness to trust and open themselves up regardless of expectations and defensiveness, which corroborates previous research that has demonstrated the importance of clients' internal and external resources in regards to making changes (Hubble, Duncan, Miller, & Wampold, 2010; Rennie, 1992). Along with this, another key ingredient that came up is the therapist's initial presentation and willingness to meet the client where she/he is and engage at the client's start point rather than the therapist's. This is particularly important in therapy relationships in which the therapist is of a majority status and client is of minority status. This calls to mind a number of prior findings, including the importance of adapting to accommodate the client's current stage of change (The Task Force, 2006), trusting in the client's judgment regarding her/his needs (Hubble, Duncan, Miller, & Wampold, 2010), and the need for therapists to view clients as unique and independent people rather than disorders (Bohart & Tallman, 1999; Lambert, Garfield, & Bergen, 2004).

Hilsenroth and Cromer (2007) emphasized the need for therapists to be especially aware of the therapeutic relationship at the earliest stage of therapy, which they argued was the best opportunity to form an enduring positive relationship. This study also found that initial impressions developed by clients, often in the first session of therapy, play a critical role in development of the client/therapist relationship. Therapist behaviors and ability to make a positive first impression seemed to influence clients by either confirming or disconfirming their expectations. This emphasizes the need for therapists to be keenly aware of relationship issues and the skill of engaging clients from the very first meeting. It is also consistent with previous research stressing the predictive power of therapists' ability to form early positive connections on overall relationship development in therapy as well as therapy outcomes (Baldwin, Wampold, & Imel, 2007; Fitzpatrick, Janzen, Chamodraka, & Park, 2006; Westra, Aviram, Conners, Kertes, & Ahmed, 2011).

Development of Therapeutic Relationship was the second major theme to emerge from this study. The relationship was described as the most important and meaningful part of therapy encounter for both clients and therapists. Both clients and therapists identified significant components of a trusting and productive therapeutic relationship as well as behaviors and attitudes that facilitated the development of trust. This main theme yielded four subthemes: *Building Trust*, *Understanding Worldview*, *Balance of Power*, and *Positive Change*.

For participants in this study, development of trust was necessary in making progress toward therapy goals. Trust was experienced by clients in this study as feeling comfortable and safe enough in the relationship to open up and become emotionally

vulnerable. Therapists distinguished between clients' trust in their expertise as well as in their ability to demonstrate warmth, acceptance and positive regard. Therapists saw the presence of both aspects of trust in the relationship as a marker of the strength of the therapeutic alliance. The presence of trust as a foundational component of the relationship also provided the resilience to overcome any challenges or misunderstandings that occurred between client and therapist.

A number of researchers have described relationship factors and therapist attributes that contribute to the development of a positive therapeutic relationship. These include respectfulness, openness, flexibility, warmth, trustworthiness, honesty, accurate feedback, active involvement, empathy, patience, acceptance, and support (Ackerman & Hilsenroth, 2003; De La Ronde & Swann, 1993; Lietaer, 1992; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Watson & Greenberg, 1994). Hilsenroth and Cromer (2007) also emphasized the need for therapists to convey support, empathy, confident collaboration, warmth, active listening, respect, understanding, and nonjudgment.

The current study identified nine factors that clients and therapists listed as important in facilitating client trust in the therapy relationship. These factors emerged from the subtheme *Building Trust*, and included willingness to trust, validation, consistency, respect, genuineness and authenticity, the ability to challenge in a positive way, acceptance and nonjudgment, listening and feeling heard, and use of humor. Although clients did not directly state the importance of validation and consistency when describing their process of developing trust in their therapists, these two subthemes

seemed to be implicitly present in statements about experiencing support and understanding.

Therapists emphasized their own efforts to engage these factors and create a relationship in which their clients experience them. They also emphasized their clients' general willingness to trust and be vulnerable as the single most important factor in building a trusting relationship. Therapists reported actively working to validate their clients' emotions, establish consistency and stability in the relationship, and communicate their genuine respect for their client's life struggles. Therapists also described being genuine with clients; expressing authentic emotion in session and expressing sincere reactions. Therapists in this study discussed the difficulties of challenging clients in positive ways and the conflict this often created between clinically necessary confrontations and the desire to maintain a warm, supportive stance. Creating an atmosphere of acceptance and nonjudgment was identified by all therapists in this study as a critical part of developing client trust. Therapists stressed their attempts to communicate unconditional positive regard and absolute acceptance of clients as individuals. Along with this, therapists emphasized the simple power of "just listening" to clients and allowing them to truly feel heard. Finally, a number of therapists remarked on their use of humor as an effective way of connecting with clients and creating a more egalitarian relationship by lightening the mood of therapy sessions and encouraging a degree of playfulness.

Clients mentioned many of these factors and stressed the efforts made by their therapists to create a trusting environment in therapy. They expressed the respect they felt for the knowledge and skill their therapists possessed as well as a "deep respect" for

their therapists as people. Clients reported being impacted by the level of genuineness and authenticity their therapists demonstrated by expressing emotions in session and sharing honest thoughts. Many clients also emphasized the ability of their therapists to directly challenge them in positive ways and confront them in a gentle, respectful manner. Therapists' ability to communicate acceptance without judgment was one of the most important aspects of building trust for clients. A number of clients commented on the unique and powerful experience of feeling truly known and accepted. Clients also stressed the experience of being listening to and really feeling heard. Finally, clients identified the use of humor as contributing to building trust by making sessions more enjoyable and feeling their sense of humor was understood by someone else.

It is worth noting that the majority of participants in this study mentioned the importance of therapist genuineness and authenticity as a significant factor in building a trusting therapeutic relationship. Therapist congruence or genuineness was found by the APA Task Force (Norcross & Wampold, 2011) to be an element that fell into the promising but insufficient research to judge category.

An important finding in regards to differences in the therapy relationship had to do with the establishment of trust in pairs where multiple differences intersected with prior negative therapy experiences. Clients in therapy pairs in which two or more salient differences were present, and who also had prior negative therapy experiences, approached their therapists with more trepidation that others. This study found that although these clients did indeed come to establish a trusting relationship with their therapists, they took somewhat longer to do so. For these clients, at least one of the relationship differences represented a difference in status in which the therapist was a

member of multiple majority status groups and the client was a member of at least one minority status group. In these pairs, the therapist's ability to create a safe environment by being culturally sensitive; communicate acceptance; take on a collaborative stance; respond positively to boundary testing; and address the differences in a direct, yet respectful manner played an even greater role in earning each client's trust. This is supported by previous findings by Constantino, Castonguay, Zack, and DeGeorge (2010); Fuertes, et al. (2006); and Comas-Diaz (2006) emphasizing the importance of therapists adapting the relationship to the client's culture, demonstrating multicultural competence, working to understand the client's voice, and explicitly addressing differences early in the therapy process in order to build the therapeutic relationship. Additionally, it is important to note that this reluctance to trust has been shown to be a protective strategy often used by members of historically oppressed groups when interacting with more privileged members of the majority culture. These results are also notable given prior research findings that White therapists are often less comfortable and less willing to address racial differences in therapy (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003).

This study found that both psychotherapy clients and therapists place great emphasis on understanding the client's worldview as one of the most important components of the therapeutic relationship. This finding calls to mind Howe (1996) who described the impact of being understood as well as understanding as strong determinants of the therapeutic relationship. In the subtheme *Understanding Worldview*, therapists described their efforts to truly understand their clients' lives and how they exist in the world so as to strengthen the relationship and achieve treatment goals. In a meta-analysis

of qualitative studies, Timulak (2007) also reported exploring feelings/emotional experiencing and feeling understood as key client-identified helpful therapy events. Clients in this study confirmed this finding and reported that the experience of being understood was one of the most powerful and affirming aspects of therapy. Understanding also emerged as an important bridge between cross-cultural differences. Clients reported that as they felt more understood by therapists, there was less of a need to discuss how differences impacted the relationship. Some clients stated that even the genuine attempt by their therapist to understand their worldview was a strong determinant of the relationship. This study found that for clients, especially clients who held minority statuses paired with majority therapists, the sense that therapists truly wanted and perhaps struggled to understand them was an incredibly meaningful and validating experience.

The current study revealed that sharing power in the therapy relationship was often critical in promoting a positive working alliance between client and therapist. Clients in this study reported that being invited to collaborate on and perhaps even determine the direction of therapy allowed them to feel empowered and helped to create a greater investment in the process. This confirms the findings by both Timulak (2007), who stated that client involvement and empowerment are important in therapy, and Henry and Strupp (1994), who reported an association between positive therapy relationships and therapists being autonomy-granting, affiliative, guiding, and noncontrolling. It also adds evidence to the Task Force's finding that goal consensus and collaboration were elements found to be probably effective in psychotherapy relationships (Norcross & Wampold, 2011). This subtheme, *Balance of Power*, seems to be another important aspect of bridging cross-cultural therapy relationships. Although

there may be an inherent power imbalance in the therapy relationship, by inviting clients who may be used to feeling powerless or overlooked to be collaborating partners in the relationship rather than a series of boxes to check off or an observer of someone else's agenda, there is greater commitment to therapy and overall progress.

Therapists in this study acknowledged the benefits of allowing clients to guide the direction of therapy, especially in regards to developing a strong therapeutic relationship. Some therapists expressed an awareness that their clients came in prepared to feel disempowered or pushed in a certain direction and seemed to test the boundaries in this area. These therapists recognized the need to share power as a way of respecting their clients' agency and honoring them as individuals. Therapists also acknowledged the sometimes difficult and frustrating side of sharing power when clients' ideas of what will be helpful contradict therapists' treatment plans. In these instances, therapists in this study found it more productive to trust in the relationship rather than push their own agenda. Along with creating a more egalitarian relationship, a few therapists expressed the need to acknowledge, own and discuss mistakes and relationship breaches openly with clients.

Symptom relief and behavioral change/problem solution were two additional client-identified helpful events found by Timulak (2007). The current study also found that clients identified symptom relief, progress toward goals, improved relationships, and greater self-esteem all contributed to developing and improving the therapeutic relationships in the subtheme *Positive Change*. Some clients mentioned specific interventions used by their therapists such as identifying personal strengths and providing new interpretations for long-standing themes in their lives, but most attributed their

improved functioning to either their therapist directly or the therapy relationship. This finding echoes Metcalf, Thomas, Duncan, Miller and Hubble (1996), who found that clients attributed positive outcomes to relationship factors. Clients in the current study noted both long-term improvements that occurred over the course of therapy as well as more immediate improvements in mood they felt after single sessions. This study also revealed that the positive changes experienced by clients were not only more likely to be attributed to the therapy relationship; they also served to reciprocally strengthen and enhance the bond between client and therapist.

Another finding that emerged from this study had to do with the degree therapists were impacted by their clients. Kottler and Hunter (2010) discussed how the therapeutic encounter can impact and instigate profound change in the therapist as well as the client. This seemed to be true for a number of therapists in the current study who acknowledged being affected in meaningful ways by their experience of the therapy relationship. They mentioned growing both personally, through the emotional and interpersonal connection with clients, and professionally in dealing with unique clinical issues their clients brought to the relationship. This phenomenon of therapy's impact on therapists is an important aspect of the therapeutic relationship that is often overlooked in psychotherapy research.

The third major theme to emerge from this study was *Shared Investment*, which revealed how great an impact the perceived level of investment of therapists and clients in the therapy process had on one another. This supports Horvath and Bedi (2002), who found that mutual commitment by therapist and client to their roles in therapy was another key element to the therapeutic relationship. Therapists identified client willingness to invest in the process and to open up as one of the most important factors

contributing to the outcome as well as the relationship. Most therapists in this study commented on the personal investments their clients made by opening up, working hard, allowing themselves to be emotionally vulnerable, facing difficult and often painful issues, and taking the risk to trust them. Therapists were more likely to attribute success and progress in therapy to their clients' level of investment. This is contrary to Metcalf, Thomas, Duncan, Miller and Hubble (1996), who found that therapists were more likely to attribute positive outcomes to therapy specific techniques rather than relationship factors.

Clients in this study acknowledged both their own level of investment in the process and that of their therapists. A number of clients described the conscious decision they made to invest in the therapy process, knowing that this would be the only way they would truly benefit. They discussed this primarily in terms of the emotional investment they committed to make in psychotherapy. Clients also mentioned how taking the risk and putting trust in their therapists was facilitated and reinforced by what they saw as their therapists' willingness to invest in them.

Along with client investment, both therapists and clients emphasized the extent to which therapists demonstrated their investment in the therapy process. The current study found that a number of therapists were willing to be flexible and accommodate clients for the sake of the relationship. This was exemplified in how therapists dealt with boundary issues and dual relationship concerns in addition to ways in which they seemed to go above and beyond their usual routine when thought to be clinically appropriate. Several clients highlighted the strong emotional impression made when they observed their

therapists extending themselves to accommodate them and go outside the traditional boundaries of therapy.

The importance of therapist interest and flexibility was noted by Ackerman and Hilsenroth (2003). Zur (2009) highlighted the distinction between boundary crossings and boundary violations in psychotherapy. He explained that boundary crossings are "proven, clinically effective interventions and are part of a well-constructed treatment plan" (p. 342). These crossings have therapeutic value and may involve such things as interaction outside the therapy office, nonsexual touch, attendance at client events, and therapist self-disclosure. Boundary violations, however, are "exploitive business or sexual relationships and are always counterclinical, negatively affecting the therapeutic process, unethical, and are likely to be illegal" (p. 342). Zur (2009) also noted that the clinical appropriateness of ethical boundary crossings are ultimately related to the context of therapy and that rigid adherence to traditional, inflexible therapy boundaries can have a negative impact on the therapeutic relationship. This study added further depth to their results by revealing that therapists' willingness to be flexible and step outside traditional boundaries typically communicated a level of genuine caring and personal investment to clients. Additionally, these instances often represented critical events in the development of the therapeutic relationship for clients in this study.

An unexpected finding in the current study was the close emotional connections experienced between clients and therapists. In Theme 4, *Emotional Connection*, clients likened their feelings of emotional intimacy toward their therapists to family relationships, close friendships, or a trusted teacher/mentor. For some, the therapy relationship was described as the closest, most emotionally intimate relationship in their

lives. Although psychotherapy clients having feelings of affection toward therapists is not a new concept or a surprising finding, clients in this study did not report any sexual attraction. In fact, a number of clients were explicit in describing their feelings as decidedly nonsexual. Instead, they expressed platonic love and gratitude. At the same time, clients also described feeling cared for, protected, liked, and accepted unconditionally by their therapists. It is important to note that clients seemed quite eager to share their feelings toward their therapists and did so spontaneously and without hesitation.

This study also found that most therapists were likely to feel affection toward their clients. Therapists reported genuinely liking their clients and feeling a real fondness for them as individuals. Given the remarks by clients, it is clear that this fondness was somehow communicated in the relationship and contributed to strengthening the client/therapist connection. Additionally, therapists in this study were more apt to attribute client pathology and challenging behaviors to the client's diagnosis rather than to the client as an individual. This tendency to make a distinction between clients and their behavior seems consistent with the Task Force recommendations (Norcross & Wampold, 2011) and prior assertions by Bohart and Tallman (1999) and Lambert and Barley (2002) regarding how the client is viewed in therapy.

Westra, Aviram, Conners, Kertes, and Ahmed (2011) found that therapists' positive reaction to clients, especially liking, enjoyment, and positive attachment, were linked with significantly less client resistance. Thompson, Hill, and Ladany (2009) found that therapists feeling clients' suffering, as well as therapists identifying with and liking clients, facilitated compassion in psychotherapy. The current study seems to support

these findings and further highlight the importance of the emotional connection between therapist and client. It also suggests a different way of viewing this emotional connection such that it is not unduly pathologized or simply reduced to loaded clinical labels like transference and counter-transference. The current study supports viewing this connection as a facilitative factor in the therapeutic relationship that both clients and therapists experience as a healthy and productive affective bond.

This theme of emotional connection came up often enough in the first few interviews that I added a question to the therapist interview protocol about the importance of liking clients with whom they work. The majority of therapists in this study stated that, although they could successfully work with a client that they did not particularly care for on a personal level, they felt they were somewhat more effective with clients whom they liked. Some therapists speculated that they are perhaps more attentive to clients they like. Others simply said that liking their clients was important in that it improved job satisfaction. A few therapists reported being actively discouraged during their training from thinking in terms of liking clients. Most therapists in the current study, however, expressed a strong need to find something to like or some way to empathize with clients in order to create a productive working alliance. Although some participants related that this emotional connection developed fairly early in the therapy process, most did not indicate how long it took to like their clients.

The current study found that clients and therapists experience the therapeutic relationship in much the same way. Each member of the therapy pair seems to be aware of most of the dynamics present in the relationship, but some were less obvious. The way in which a client initially approaches the therapy relationship from the type of referral to

previous therapy history can have a great impact of expectancy and trust. Many clients in this study also seemed to form an immediate connection with their therapist in the initial sessions. Trust, understanding, power sharing, and positive change were shown to be essential factors in the development of a positive therapeutic relationship. Mutual investment and forming an emotional connection were also revealed to be critical elements in the experience of the therapy relationship. In addition, clients in this study were more likely to attribute positive therapy outcomes to the therapy relationship or to the therapist, while therapists were more likely to attribute positive outcomes to client investment in the process.

According to Muran (2007), the therapeutic relationship can be viewed as an ongoing intersubjective negotiation between the various identities of the client and therapist, in which differences such as race, culture, sexual orientation, and gender are integral to the negotiation process. Part II of this study involved client and therapist *Experience of Differences* in the cross-cultural therapeutic relationship. The term "difference" was broadly defined and generally left up to clients and therapists to interpret. This is in keeping with Nezu's (2010) assertion that any difference, especially one present during a person's development, is a potentially important part of her/his identity. The broad definition is also consistent with Greene (2007), who pointed out that each individual has multiple overlapping identities, and any given dimension of a person's identity may be more or less salient depending on the context and developmental stage. The main themes that emerged from participants' experience of differences in the therapy relationship were *Dimensions of Identity, Differences as Enhancing the Relationship, Building on Common Ground*, and *Power and*

Responsibility. Although this study was designed to explore the experience of differences in cross-cultural therapy relationships, one unexpected finding was that both clients and therapists were far more interested in identifying and discussing similarities in their therapy relationship rather than differences. Clients also reported that, although addressing cross-cultural differences was important in the development of the relationship, it was not always essential to make them an explicit centerpiece of the therapy process once a sense of mutual trust and understanding was established.

In the first main theme of Part II, *Dimensions of Identity*, clients and therapists in this study identified and addressed differences they experienced as salient in their therapy relationships. Overall, the current study found that therapists were able to identify a greater number of differences that existed between themselves and their clients than were clients. This finding is expected given that therapists typically have much more information about clients' psychosocial history. This study also found that therapists seemed to assign more meaning to the differences in the relationship than clients, with the exception of age and experience. Therapists also demonstrated more sensitivity to the ways in which differences might impact the therapy relationship. Again, these findings may reflect the imbalance of background information on one another available to therapists and clients. It may also be due to the extensive education and training psychologists receive as a part of doctoral level preparation in psychology on the impact of various psychosocial factors and multicultural identities on individual functioning and interpersonal relationships. It may also be the result of clinical experience working with many different clients.

The current study revealed that clients seemed more likely to minimize or overlook differences between themselves and their therapists, even obvious visible differences such as race and gender. This finding may also reflect the training in therapy dynamics, including the potential impact of multicultural issues, psychologists receive. In other words, it is possible that therapists may simply be more sensitive to identifying differences and their potential impact on the therapy relationship. However, the fact that this finding seemed more likely to occur with clients of color paired with White therapists suggests some other possibilities. These clients of color may have felt uncomfortable calling attention to or initiating any discussion about race and ethnicity with a White, male interviewer. It is likely that the fact that I hold a number of majority statuses, many of which are the same as their therapists, had an impact on the interview responses I elicited. Although I attempted to make explicit and address the differences between participants and myself during the course of the interviews, the impact of my identities may have played a significant role in the type of information I collected.

Another possible explanation for this finding has to do with participants' stages of identity development as outlined by Helms' People of Color Racial Identity (PCRI) model (Helms, 1995). There is an enormous amount of empirical literature devoted to Helms' racial identity model as it has evolved over the years, and it has been operationalized for practical use in both counseling process and outcome research (Atkinson, 2004; Ponterotto, et al., 2000). The PCRI consists of five levels or ego statuses involving attitudes, behaviors, and emotional states, including (a) *conformity,* representing an external self-definition, devaluation of one's own racial group, and allegiance to the dominant (White) group's standards of merit; (b) *dissonance,*

characterized by ambivalence and confusion about one's own group identity; (c) *immersion/emersion*, in which one's own racial group becomes idealized and the dominant White group is denigrated; (d) *internalization*, in which the individual develops a sense of positive identification with one's own racial group and an ability to respond objectively to White society; and (e) *integrative awareness*, characterized by an increased positive racial self-identity and valuing of one's multiple and collective identities (Helms, 1995). It is likely that clients of color in this study may have responded to my interview questions around differences, especially racial/ethnic differences, based on their identity status as defined by the PCRI. This also may explain some White therapists' reported frustration when attempts to discuss issues involving REC with clients of color went nowhere.

Another finding that emerged from this study was that, although therapists were more likely to identify possible challenges that might arise as a result of cross-cultural differences in the relationship, clients were more likely to discuss differences as positive or helpful aspects of the relationship. Once again, this finding may be the result of therapists' training which focused on addressing potential challenges. This finding may also reflect clients' identity development status as discussed above as most therapists in this study held one or more majority statuses (i.e., White, heterosexual, higher SES, etc.). There also exists an inherent power differential in the therapy relationship itself wherein the therapist is in a position of power relative to the client. This finding may be indicative of clients' desire to affiliate, identify with, or please the person holding more power in the relationship. It is also worth mentioning that this finding may simply represent a true benefit clients received from the experience of engaging in a close,

meaningful relationship with someone different from themselves in a number of salient areas.

All of the areas of difference mentioned by participants in the current study were combined under 11 common subthemes: Race, Ethnicity, and Culture, Gender and Gender Identity, Religion, Sexual Orientation, Socioeconomic Status, Age and Experience, Relationship Status and Relationship Orientation, Life Experience and Trauma, Personality Style, Appearance, and Language.

This study found that White therapists working with clients of color expressed a heightened awareness and sensitivity to differences in the relationship around REC as well as potential challenges that may occur. These therapists often initiated discussions on REC and indicated a strong desire to practice "multicultural sensitivity" in their work by examining how their clients' race, ethnicity, or culture may be intersecting with their presenting problems, though none of these therapists endorsed employing any specific culturally adapted treatment approaches. This seems to contradict some previous research that found White therapists less comfortable addressing race in therapy (Gushue & Constantine, 2007; Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003; Utsey, Gernat, & Hammar, 2005). Additionally, this study found that White therapists working with clients of color demonstrated a certain level of awareness of their own whiteness due to prior personal work around White identity development and examination of privilege. This study also found that therapists of color working with White clients demonstrated heightened awareness of REC dynamics but were less likely to initiate conversations regarding REC differences in the therapy relationship.

This study found that gender differences in the therapeutic relationship were typically not addressed in a direct way. Male clients with female therapists were more likely to report that having a woman as their therapist was either a positive thing or were indifferent. This finding may reflect a conflict between the emotional nature of psychotherapy and traditional views of masculinity/male gender roles. Some male clients may feel more comfortable expressing emotion or appearing emotionally vulnerable with women rather than other men. In the current study, men in general were much less likely to indicate they had ever reflected on the role of gender or gender identity in their lives. Therapists who were women working with male clients reported being mindful of the gender difference and any potential impact it may have on the relationship, but did not report addressing this difference directly. Overall, despite some previous research to the contrary, no qualitative differences in mixed gender therapy relationships were found. In fact, male clients paired with women therapists indicated a preference for female therapists.

This study did find some support for previous research indicating that highly religious clients have been found to perceive religious issues as a central aspect of counseling (Wyatt & Johnson, 1990). In terms of religious differences, however, the current study found that religious differences between clients and therapists did not have a substantial impact on the therapy relationship. Some clients expressed initial hesitation about initiating discussions regarding their religious beliefs due to religious differences, but they stated that, as their sense of trust and understanding grew in the relationship, they felt increasingly more comfortable bringing religion and spirituality into therapy sessions. This finding partially supports Ripley, Worthington, and Berry (2001), who

reported that clients who identify as highly religious may anticipate negative experiences in psychotherapy with a secular or nonreligious therapist. The current study also suggests that a strong positive therapeutic relationship based on trust and understanding can overcome any negative expectations based on religious differences.

Most therapists in therapy pairs with religious differences expressed being comfortable discussing religious and spiritual beliefs directly and further connected this issue with their attempt to understand their clients' worldviews, specifically their sources of comfort and strength. Interestingly, therapists in this study who identified with a particular religion appeared to be more concerned about maintaining boundaries around bringing religious discussions into therapy than therapists who identified with no particular religion. This finding may be due to concerns about therapist self-disclosure or being perceived as proselytizing, especially in a community with a clear majority religious group.

Although it was not explicitly stated, the heterosexual therapists working with self-identified gay and queer clients in this study seemed to practice gay affirmative therapy as defined by Bieschke, McClanahan, Tozer, Grzegorek, and Park (2000) and Morrow (2000). Some therapists reported struggling to truly understand their gay clients' experience in the world, particularly around issues of oppression and religious conflict, but expressed a sincere desire to do so. Sexual minority clients in this study reported very strong and productive therapeutic relationships with their therapists. They also reported feeling quite comfortable discussing issues of sexual orientation as they pertained to their reasons for seeking therapy. The findings of this study confirmed those of Burckell and Goldfried (2006) that LGBT clients reported that establishing a trusting,

collaborative therapy relationship was more important than whether or not sexual orientation was the focus of therapy.

One unexpected finding to come from the current study involved the impact of age and experience on the therapeutic relationship. At present, there is very little empirical research addressing the issue of age differences in psychotherapy. Although age is included in a number of guidelines and recommendations for practice, this area of diversity is not well-researched. Several participants identified age as an important and meaningful difference in their therapy relationships. Unlike some of the other traditional demographic categories identified as differences by study participants, such as REC and gender, clients appeared to be more aware of the difference in age as well as the implications for the therapy relationship. In fact, therapists were less likely to view age as an important difference at all. Almost all of the clients saw the difference in age between them and their therapists as having some impact on the relationship. Although not addressed in the current study, this may reflect younger clients' degree of affiliation with patriarchal religious and cultural values which emphasize deference and respect for elders. In contrast, a number of therapists described not feeling their true age, and therefore not being consciously aware of the actual difference in age between them and their younger clients. Most clients and therapists reported that age differences were not addressed in their therapy relationships. This finding is particularly meaningful as age is an often overlooked area of diversity.

Another unexpected finding was in regards to the impact of relationship status and relationship orientation on the therapeutic relationship. Therapists were more likely to acknowledge this area of difference, perhaps because of the imbalance of knowledge

about their clients' personal lives. Clients, however, were more likely to identify this as a meaningful difference and discuss the implications. These findings are important as they represent another overlooked area of diversity in the client/therapist relationship. It is especially relevant for work with LGBTQ individuals in light of societal discrimination regarding marriage equality.

Additional differences in therapy relationships noted by clients and therapists in this study included life experiences and trauma, personality differences, appearance, and language. Encountering these types of differences is expected in psychotherapy and is often part of the reason for clients seeking mental health treatment. The current study found that therapists generally approached these differences with a sense of respect and a desire to gain greater understanding of their clients, which ultimately contributed to their therapy relationships.

The current study revealed that, in some instances, minority status clients with majority status therapists may either downplay the importance of minority statuses or resist addressing them in the context of the therapy relationship even when encouraged by therapists. This was true for differences in REC, religion, and relationship status. However, this pattern was not found in therapy pairs with differences in gender and gender identity, sexual orientation, or SES. Overall, therapists demonstrated greater awareness of meaningful differences and their impact on the therapeutic relationship with the exception of age and experience, as well as relationship status and relationship orientation. Therapists in this study also attempted to directly and explicitly address most differences identified as meaningful in a respectful and sensitive manner with clients. One important finding of the current study is that challenges resulting from meaningful

differences between clients and therapists are generally mitigated by a strong therapeutic relationship characterized by trust, understanding, mutual investment, power sharing, and emotional connection.

These findings support Comas-Diaz's (2006) recommendations to pay special attention to cultural issues while also focusing on the client's individual needs, and the importance of working to understand the client's voice and to develop trust and credibility, as well as demonstrating cultural empathy in cross-cultural therapy encounters. They are also consistent with previous research on adapting the therapeutic approach to individual client characteristics, cultural backgrounds, and sociopolitical statuses (Norcross & Wampold, 2011b; Sue & Lam, 2002), exploring and making explicit the meaning of differences such as gender, age, and ethnicity and the ways they manifest in order to build the therapeutic relationship (Constantino, et. al, 2010; Quinones, 2007).

The second theme to emerge from Part II was *Differences as Enhancing the Relationship,* in which participants revealed the benefits of having differences within the therapy pairs. This study found that one therapist and a number of clients reported that the differences between them and their therapy partners served to enhance the therapeutic relationship. These participants reported that they appreciated the different perspectives and different experiences of "who we are in the world" that their cross-cultural relationship provided. It may be that therapists who genuinely made themselves known to clients in therapy and used themselves as a tool in the therapeutic relationship allowed clients to perceive the differences in the dyad in a more positive light and/or minimize negative perceptions associated with particular differences. For some minority status

clients, the therapy relationship seemed to represent a unique opportunity to engage in a relationship with someone of majority status. Although the research is mixed on client-therapist matching, this finding indicates that matching may be contraindicated for some clients. Some minority status clients in particular may benefit from working with multiculturally competent majority status therapists.

One important and unanticipated finding in the current study was that, although the emphasis of study was on cross-cultural differences, both clients and therapists were much more likely to identify similarities in their therapy relationships. The major theme *Building on Common Ground* showed that clients and therapists preferred to talk about similarities and seemed to go to great lengths to find things in common with one another and identify with these commonalities. Clients in this study expressed a clear preference to look for commonalities in order to relate to their therapists from the very first sessions. It is not unusual for clients to want to identify with their therapists; however, this was also true for therapists in this study who expressed a desire to look for avenues of relating and things to like about their clients – even if it is simply making contact with clients' pain. In addition, both clients and therapists consistently steered the direction of the interviews away from discussion of differences and toward similarities within the relationship. It is important to reiterate here that each participant pair was selected for inclusion in the study due to meaningful differences in their relationships.

It is possible that clients and therapists were more inclined to identify similarities and focus their discussion on these due to the potential for conflict when that could occur by focusing on differences between them. Clients in particular seemed to perceive the idea of difference in a negative light. This was apparent in the ways that clients often

minimized the impact of differences after naming them. It may be that for many clients, the idea of differences represented a threat to the therapeutic bond they felt with their therapists. For some clients and therapists, difference may have been synonymous with emotional and relational distance.

Overall, more areas of similarity were identified than differences. The similarities mentioned by clients and therapists included gender, religion, sexual orientation, ability status, SES, parent status, perceived beliefs, values, personality style, age, hobbies and interests, educational background, college major/career field, employer, family dynamics, sense of humor, familiarity/experience with therapy partner's culture, social justice/political views, research interests, and the experience of minority status.

Some studies have suggested a relationship between improved therapeutic alliance and client-therapist matching on age, religious beliefs, and values (Hersoug, Hoglend, Monsen, & Havik, 2001; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Worthington, & Berry, 2001), though the evidence is mixed for matching on ethnicity (Farsimadan, Draghi-Lorenz, & Ellis, 2007; Fuertes, et al., 2006; Ricker, Nystul, & Waldo, 1999). Although this study found some support for client preferences for therapists with similar identities, it seems that the types of similarities between clients and therapists were less important than the simple fact they exist. For example, clients did not express feeling that shared gender or religious beliefs were more meaningful in the development of the relationship than having similar hobbies or research interests. Clients and therapists in the current study were able to find common ground regardless of how hard they had to search or how many salient differences existed between them.

The last theme to emerge from this study was *Power and Responsibility*, in which therapists expressed a clear sense of responsibility to address relationship differences. Most therapists reported that, as the person with the position of greater power in the relationship, it is the responsibility of the therapist to bring up differences, make then transparent, and attempt to create an atmosphere in which clients feel comfortable discussing them. Constantino, Castonguay, Zack, and DeGeorge (2010), in a review of research on the impact of demographic variables on the formation of the therapeutic relationship with adolescents, suggested that therapists explore and make explicit differences such as gender, age, and ethnicity early in the therapy process in order to build the therapeutic relationship. The findings in the current study seem to support therapists' making differences explicit with adult clients as well.

Interestingly, some therapists holding minority statuses working with majority status clients expressed some reluctance to initiate conversations regarding differences. These differences seemed to go unacknowledged in the therapy relationship even though both members separately acknowledged awareness of the differences in their interviews. This finding seems to highlight the complexity of power dynamics and sociopolitical statuses in the therapeutic relationship. It also suggests that when the therapist holds a minority status in relation to the client, the sense of responsibility to address this dynamic is somehow mediated.

Additionally, some therapists who reported directly addressing differences in the relationship repeatedly with clients expressed frustration that these discussions seemed to go nowhere. In contrast, some clients in these therapy pairs stated they could not recall whether the differences were addressed or not. This seemed to occur with clients who

appeared to be in the initial statuses of Helms' PCRI model and therapists who were approaching the relationship from a more advanced identity development status. It appears that this demonstrates a possible communication breakdown between some clients and therapists regarding discussions of difference. In contrast, for those clients who appear to be in advanced stages of identity development, initial acknowledgement and initiation of discussion around differences may be sufficient. This finding suggests that it is particularly important for therapists, as members of the therapy pair with more power, to continue to address differences and initiate discussions throughout the therapy process with some clients, especially those in initial stages of identity development.

This also represents a further dimension in the discussion of differences. A difference in identity development status may occur between client and therapist on each dimension of identity. This is an important and largely overlooked dynamic in psychotherapy research. The current emphasis on therapists' multicultural competence seems to assume a unidirectional interaction of therapists' skill on clients' identities. The results of this study, however, suggest a more complex interaction based on the intersection of the identity development statuses of both therapists and clients on multiple dimensions of identity. Therapists must be aware of their own identity development statuses along various salient identities and the assumptions associated with them. In addition, they must consider the identity development of their clients and where the intersections occur within the relationship. Therapists who fail to recognize potential conflict in this area risk pursuing an agenda that is incompatible with their clients' needs and ultimately damaging the relationship or alienating their clients.

This study confirmed the importance of acknowledging clients' prior experiences, referral sources, and initial impressions. It also revealed that a therapeutic relationship based on trust, understanding, shared power, positive change, shared investment, and a positive emotional connection were important aspects of the experience of the therapeutic relationship for participants. The current study also found that some differences in the relationship, particularly REC, were influenced by identity development status. It was further revealed that a strong therapeutic relationship served as a bridge to connect clients and therapists differences. An unexpected finding showed that clients and therapists were more likely to discuss similarities in their therapy relationships rather than differences. And, finally, therapists in this study reported feeling responsible to address cross-cultural differences in therapy.

The results of this study support Fuertes, et al. (2006), who found a strong positive association between clients' perceptions of their therapists' multicultural competence and ratings of the therapeutic alliance, including feeling understood and experiencing a trusting bond with their therapists. This current study also confirms many of the findings of Chang and Berk (2009), who found that clients in cross-racial therapy dyads who were satisfied with their therapy experiences indicated their therapists adopted an active rather than passive role in therapy; disclosed personal information; and were viewed as caring, sensitive, and attentive. They also found that satisfied clients perceived that racial/ethnic differences were irrelevant to their presenting problem and therapy goals and that there were significant benefits from working with a racially different therapist. Satisfied clients in this study also seemed to place greater emphasis on shared aspects of identity with their therapists, reported that their concerns were adequately

addressed by their therapists, and described their therapists as culturally responsive and skilled enough to work through misunderstandings related to race. The current study expands the findings of Chang and Berk (2009) to other areas of diversity beyond race, emphasizing the absolute importance of developing a trusting therapeutic relationship where the client feels understood and empowered in working toward a successful therapy outcome regardless of cross-cultural differences.

Limitations and Implications for Future Research

There are some important limitations to the current study. These include limitations related to sample demographics, the principal investigator, and data collection methods. The first limitation has to do with the participant demographics. Although the therapy pairs included in this study represented a variety of cross-cultural differences, the majority of participants identified as White, heterosexual, and/or male. Seven of the 26 participants (two therapists and five clients) identified as people of color. Despite specific efforts to recruit more participants of color, no African American or American Indian participants were included in the study. One African American psychologist expressed interest; however, at the time of the study he was not yet licensed and therefore did not meet inclusion criteria. It is also worth noting that most of the study participants resided in Utah, where African Americans and American Indians comprise less than 1% of the population and approximately 1.4% of the population respectively (utah.gov, 2011). Due to the relatively small number of participants of color, limited conclusions may be drawn as to how the experience of participants of color in this study may compare to others.

It is difficult to predict how the results of the current study would have been impacted by the inclusion of a greater number of participants of color. It is possible that additional or alternative relationship themes would have emerged if, for example, African American participants were represented in the study. The intersection of therapist and client racial/ethnic identity development may have been found to play a more significant role. The importance of directly acknowledging and addressing the impact of RAC, client mistrust or *healthy cultural paranoia* (Whaley, 2001), fear of disclosing perceived vulnerabilities (Lee, 1999), and the sociohistorical context of oppression (Caldwell & White, 2005) may have also emerged as important themes in the psychotherapy relationship. It is worth noting, however, that in a study of clients and therapists in racially/ethnically mismatched pairs, Chang and Berk (2009) reported that clients of color who were satisfied with their therapy experiences indicated their therapists adopted an active rather than passive role in therapy; disclosed personal information; and were viewed as caring, sensitive, and attentive. They also reported that satisfied clients perceived that racial/ethnic differences were irrelevant to their presenting problem and therapy goals and that there were significant benefits from working with a racially different therapist. There remains a critical need for further research on experiences of cross-cultural differences in the therapy relationship with people of color, particularly African Americans.

In addition, only two clients in the study were women, and only three clients identified as LGBT. All therapists in the study identified as heterosexual, and no participants identified as lesbian or bisexual. It is notable that the majority of client participants were men, as previous research in psychotherapy indicates that women seek

therapy services at much higher rates than men, and therapist participants reported higher percentages of women clients on their caseloads. The high rate of male participants may relate to my own male gender as the principal investigator, suggesting men were more likely to volunteer for a study conducted by a man. This may also be the result of male clients being perhaps more motivated by the $25 compensation.

Further, all of the participants who identified as being associated with a particular religious group were Christian. No members of non-Christian religious groups were included. Finally, all participants were recruited from the Intermountain West region of the US and were involved in therapy through private practices or university counseling centers. All therapists involved in the study were licensed psychologists with similar training. It is likely that clients and therapists representing cultural groups, backgrounds, and regions not included in this study would report different experiences in psychotherapy. Future research on cross-cultural therapeutic relationships should include a more diverse participant sample and a greater variety of differences within therapy pairs. Future research in this area should also attempt to recruit participants from a greater variety of practice settings (e.g., VA hospitals, inpatient psychiatric units, community mental health clinics, etc.), a greater variety of mental health professionals (e.g., social workers, licensed professional counselors, etc.), and other geographic regions.

A second limitation to the current study involves me as the principal investigator. As a White, heterosexual man interviewing participants of color, women, sexual minorities, and others who represented different sociopolitical statuses, it is possible that my own identities impacted the questions I asked, the information I was given, and my

interpretation of the information. Throughout the study, I attempted to bracket my personal reactions and opinions as described in Chapter 2, however, my visible identities and the things they represent may have been barriers to viewing and understanding the true lived experience of participants, particularly those participants with minority status identities. In future research on cross-cultural therapy, it may be beneficial to have multiple interviewers representing different areas of diversity and minority statuses to minimize any possible power dynamics between interviewer and participants.

A third limitation has to do with participants' self-selection. Each of the participants in this study reported having an overall positive therapy experience with her or his therapy partner. Although I did not expect clients or therapists who reported negative therapy experiences to express interest, it must be noted that the current study's finding represent only positive therapy experiences. This study does not address the experiences of those who have had unsatisfying cross-cultural therapeutic relationships, and it would be a mistake to simply take these findings and assume the opposite is true for those individuals. Further research on cross-cultural therapy should attempt to include people who have had negative therapy experiences.

Two more limitations to this study have to do with sources of data. The majority of the data collected came from individual participant interviews. None of the pairs included in this study volunteered to participate in direct observation of a therapy session. Of note is that the therapists in this study appeared to demonstrate more guarded or reluctant attitudes toward video recording a therapy session than clients. This may be the result of therapists' discomfort with having their work intruded upon, performance anxiety, or fears of being judged. Additionally, only nine participants (five therapists and

four clients) responded to participant check questions. It is quite possible that alternative sources of data would have produced a greater variety and depth of information regarding the experiences of clients and therapists. It would be beneficial for future studies to include alternative sources of data as a requirement for participation while maintaining participant confidentiality.

Some additional implications for future research have to do with inclusion of age and other dimensions of identity in addition to identity development status as important aspects of diversity in research studies involving cross-cultural therapy as well as psychotherapy process and outcome research. Research on the impact of diversity variables such as age, relationship status, and relationship orientation is currently lacking in the field of multicultural counseling and therapy. As shown in this study, these identities can be salient for clients and therapists alike. The intersection among these variables and others, and their impact on the therapy relationship, is also an area in need of further exploration. In addition, identity development status can have a tremendous impact on how differences in the therapy relationship are acknowledged and addressed. The impact of client and therapist identity development statuses must be explored in order to better understand the complexity of these interactions and how they affect therapy relationships and outcomes.

Another area for future research on the therapeutic relationship is the impact of length of treatment. The shortest length of treatment reported by participant pairs in this study was four months. Examining therapy dyads with shorter treatment lengths may reveal additional information on the intersection of treatment length and development of

the therapeutic relationship. Length of treatment may also be an important factor in building the emotional connection and therapists liking their clients.

Finally, there is further research needed to explore the relationship between reluctance to focus on differences/emphasis on similarities in the therapy relationship and dimensions of identity. Clients' and therapists' perception and understanding of the meaning of difference in general and specifically in relation to the therapy relationship is poorly understood.

Implications for Practice and Training

The results of this study have a number of implications for psychology practice and training. Most of these implications involve developing and strengthening the therapeutic relationship. The current study showed that a strong therapeutic relationship based on trust, understanding, power sharing, and positive change between client and therapist can be sufficient to overcome challenges related to differences. Therapists must be aware of the factors that contribute to a positive relationship with clients, particularly early on in the therapy encounter. This includes being mindful of the impact of basic relationship building skills such as validation, consistency, respect, genuineness and authenticity, the ability to challenge in a positive way, acceptance and nonjudgment, listening and feeling heard, and use of humor. Psychology training programs should also emphasize development of these skills in graduate programs over specific therapy techniques.

Client expectancy and readiness to engage in a trusting relationship was found to be heavily influenced by past experience and referral source. This highlights the

influence of the referral process. One major implication for practice in regards to this finding is the importance of building positive relationships with potential referral sources in the community. These sources can be other mental health professionals, medical professionals, religious leaders, social service personnel, educators, or any trusted leaders in the community. Establishing a positive presence in the local community can set potential clients on course for experiencing a positive therapy outcome before they even attend the initial session.

Awareness of identity statuses within the therapy relationship also has critical implications for practice and training. Therapists must be aware of the power dynamics between themselves and clients and the potential impact of majority versus minority statuses. Therapists and trainees should feel comfortable addressing the various dimensions of identity that are present in the therapy dyad and how levels of identity development may influence clients' willingness to discuss differences.

Another finding of the current study was that client and therapist investment had a great impact on the course of therapy and the relationship itself. Both therapists and clients put a great deal of weight on client investment in the therapy process. In fact, therapists in this study attributed most of the success in therapy to this factor. It is important for clinicians to be aware of the importance of client investment and address this in therapy. Therapists must also be mindful of what their actions communicate to clients about their level of investment in the therapy process. Clients reported gestures from their therapists such as being flexible with fees, answering crisis calls, and attending outside events communicated investment in them and helped to strengthen the relationship. These boundary issues are largely for individual clinicians to determine on

a case by case basis, but careful consideration should occur regarding the clinical utility of being flexible with certain clients before making absolute policies.

One final issue impacting practice and training is awareness of the power of the therapeutic relationship and the importance of the emotional connection between client and therapist. Clients in this study reported experiencing a degree of emotional closeness in their therapy relationships that promoted feelings of safety, comfort, and acceptance, as well as positive growth. Too often it seems that therapists are quick to avoid, minimize, or pathologize any emotional connection with clients when in fact, this can be a critical healing component of a healthy therapy relationship. Clients in this study demonstrated an awareness of appropriate relationship boundaries with their therapists; however, they also compared these relationships to those of family and close friends. Therapists in this study also expressed sincere affection and "liking" towards their clients and recognized this as a helpful aspect of the relationship. Clinicians and training programs should address this emotional connection between client and therapist as an important and expected part of the therapy encounter and acknowledge that there is a degree of intimacy involved in psychotherapy. There is a desire to relate to one another and find common ground. The burden is on therapists to determine when this emotional connection becomes unhealthy and potentially damaging or unethical, but it would seem that acknowledging it exists and learning how to address it with clients is a better way of preparing than trying to ignore and avoid it. Trainees should be taught that it is certainly normal –and may be helpful--to care for and like their therapy clients.

Implications for Social Justice

The current study further highlights the need to focus on awareness of multicultural issues and the various identities that exist and intersect within the therapeutic relationship. It is particularly important to acknowledge and address issues around majority/minority status and power in the therapy encounter. Given the closeness and emotional investment involved in psychotherapy, therapists have a unique opportunity to promote social justice issues and raise awareness on a micro-level. This can be even more powerful when client and therapist experience multiple salient differences and differences in status in their relationship. One client in this study likened his therapist to an activist, stating that she is "an activist through therapy, through being a therapist, which is a really unique, really intimate way of being an activist - and really powerful." I fully agree with this description; and, although it is not the therapist's job to persuade clients to her or his way of thinking, it is the therapist's responsibility to introduce clients to alternative ways of viewing their circumstances. This includes raising awareness of how clients' various and intersecting identities impact their way of being in the world; further, a therapy relationship based on trust, understanding, and shared power, where clients can feel accepted and cared for, is a perfect microcosm in which to experiment with new ways of being.

Personal Implications

As the principal investigator, conducting this study has had a profound impact on my clinical practice and how I approach psychotherapy. The data collection, analysis, and final write up of this project have spanned my pre-doctoral internship at a university

counseling center and part of a postdoctoral residency at a VA hospital. I continue to reflect on my interviews with clients and therapists and the wisdom they contain. I imagine I will continue to do so for the rest of my professional career. I truly feel honored to have been granted access to the relationships described in this dissertation. I must also acknowledge my own parallel process of becoming emotionally connected to the participants with whom I have shared this experience. Their words have become an important part of my own inner dialogue as a psychologist.

I have noticed that I am much more mindful of the relationship between my clients and myself. This is true for both psychotherapy and testing clients. I am more purposeful in my attempts to form a positive therapeutic relationship with clients, keeping in mind those themes and subthemes identified by participants in this study as critical in developing trust. I am more apt to allow clients to know me, as clinically appropriate, and focus on creating a more egalitarian relationship in the tradition of feminist therapy while also remaining mindful of professional and ethical boundaries. I have found that I put a great deal of effort into establishing a trusting relationship early on in my work with new clients and pay more attention to my personal reactions to each individual.

I also make a point to acknowledge differences and similarities in my therapeutic relationships with clients. I try to do this in a direct and respectful manner and initiate ongoing conversations with clients regarding the nature of differences/similarities that may exist along various aspects of our identities and how they may impact our relationship. In addition, I try to consider where I seem to be in relation to my clients in terms of identity development status in these areas. As with a number of therapists I

interviewed, I see this as an ongoing learning process with no clear arrival date. I continue to experience successes and failures, but I try to acknowledge both and learn from them.

Finally, through the process of this study, I have come to acknowledge and accept that the therapeutic relationship I share with my clients comes with an emotional connection that is often both meaningful and intimate to each person involved. Rather than shy away from this or minimize its impact on my clients and myself, I am learning to honor and embrace this important aspect of psychotherapy, make it explicit with my clients in a way that allows us to discuss the emotions and meaning present in our relationship, and use it in a way that is clinically appropriate to assist my clients in progressing toward their goals.

Conclusion

The current study examined the lived experiences of clients and therapists in cross-cultural therapeutic relationships. A total of 26 participants representing 13 different cross-cultural psychotherapy dyads were studied using qualitative methodology. Findings from this study revealed that developing a strong therapeutic relationship based on trust, understanding, shared power, and positive change had a substantial impact on both clients and therapists regardless of differences within the therapy dyad. Clients and therapists described how their therapy relationships developed, starting with the referral and initial encounter, and how the relationships were shaped over the course of counseling. Participants also described their experiences related to acknowledging and addressing differences as well as similarities between them and their therapy partners.

Both clients and therapists highlighted the power of the therapeutic relationship and the emotional connection they experienced within it.

This study confirmed a number of previous research findings and revealed new insights into the phenomenological experience of the cross-cultural therapeutic relationship and the impact they can have on clients and therapists. The current study found that experiences of clients and therapists fell into two main areas: Part I *Experience of Relationship* and Part II *Experience of Differences*. These two areas yielded eight major themes, with four themes in Part I: *Referral and Initial Impressions, Development of Therapeutic Relationship, Shared Investment*, and *Emotional Connection*, four themes in Part II: *Dimensions of Identity, Differences as Enhancing the Relationship, Building on Common Ground*, and *Power and Responsibility*, and several important subthemes. This study confirmed the importance of acknowledging clients' prior therapy experiences and referral sources as well as the impact of initial impressions. It also revealed that establishing a positive therapeutic relationship between client and therapist based on trust understanding, shared power, and positive change is an essential component of successful psychotherapy. A shared investment from client and therapist in addition to a positive emotional connection were also found to be important aspects of the experience of the therapeutic relationship for participants in this study.

The current study also found that clients and therapists differed in regards to the cross-cultural differences each perceived as salient to the therapy relationship. Additionally, some differences, particularly REC, were found to be influenced by clients' identity development status. It was further revealed that a strong therapeutic relationship based on trust and understanding served as a bridge to connect clients and therapists

despite any challenges resulting from perceived differences. Some study participants even acknowledged the benefit of engaging in a therapy relationship with someone different from themselves. An unexpected finding showed that clients and therapists demonstrated a clear preference to identify and discuss similarities in their therapy relationships and build on common ground. And finally, therapists in the current study took on the responsibility, as individuals with more power in the relationship, to address cross-cultural differences in therapy.

These findings highlight the important and inspiring work that can be accomplished by therapists and clients in cross-cultural therapy. They also provide several examples of the power of the therapeutic relationship a critical component of psychotherapy outcomes. As the findings are considered with respect to current training, practice, and social justice efforts, it is essential that the field of psychology acknowledge the transformative nature of the unique relationship that takes place between client and therapist within the therapy encounter. It is this relationship that allows differences to be embraced and celebrated. Within this authentic meeting between two human beings the necessary elements for growth and change emerge.

REFERENCES

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy, 38*, 171-185.

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33.

Ahnallen, J. M., Syemoto, K. L., & Carter, A. S. (2006). Relationship between physical appearance, sense of belonging and exclusion, and racial/ethnic self-identification among multiracial Japanese European Americans. *Cultural Diversity & Ethnic Minority Psychology, 12*, 673-686.

Alyn, J. H., & Becker, L. A. (1984). Feminist therapy with chronically and profoundly disturbed women. *Journal of Counseling Psychology, 31*(2), 202-208.

American Psychological Association. (1978). Guidelines for therapy with women: Task Force on Sex Bias and Sex Role Stereotyping in Psychotherapeutic Practice. *American Psychologist, 33,* 1122-1123.

American Psychological Association. (1995). *Template for developing guidelines: Interventions for mental disorders and psychosocial aspects of physical disorders*. Washington, DC: Author.

American Psychological Association (2000). Guidelines for psychotherapy with lesbian, gay, and bisexual clients. *American Psychologist, 55,* 1440-1451.

American Psychological Association (2002). Ethical principles of psychologists and code of conduct. *American Psychologist, 57*(12), 1060-1073.

American Psychological Association (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58,* 377-402.

American Psychological Association (2004). Guidelines for psychological practice with older adults. *American Psychologist, 59*, 236-260.

American Psychological Association (2008). Resolution on religious, religion-based and/or religion-derived prejudice. *American Psychologist, 63*, 431-434.

American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271-285.

American Psychological Association Task Force on Socioeconomic Status. (2007). *Report of the APA Task Force on Socioeconomic Status.* Washington, DC: American Psychological Association.

Andres-Hyman, R. C., Ortiz, J., Anez, L. M., Paris, M. Davidson, L. (2006). Culture and clinical practice: Recommendations for working with Puerto Ricans and other Latinas(os) in the United States. *Professional Psychology Research and Practice, 37*(6), 694-701.

Armengol, C. (1999). A multimodal support group with Hispanic traumatic brain injury survivors. *Journal of Head Trauma Rehab, 14*(3), 233-246.

Atkinson, D. R. (1994). Multicultural training: A call for standards. *The Counseling Psychologist, 22*(2), 300-307.

Atkinson, D. R. (2004). *Counseling American Minorities* (6th ed.). New York: McGraw Hill.

Atkinson, D. R., & Lowe, S. M. (1995). The role of ethnicity, cultural knowledge, and conventional techniques in counseling and psychotherapy. In J. G. Ponterotto, J. M. Casa, L. A. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 387-414). Thousand Oaks, CA: Sage.

Atkinson, D. R., Maruyama, M., & Matsui, S. (1978). Effects of counselor race and counseling approach on Asian Americans' perceptions of counselor credibility and utility. *Journal of Counseling Psychology, 25*(1), 76-83.

Azhar, M. Z., & Varma, S. L. (1995a). Religious psychotherapy as management of bereavement. *Acta Psychiatrica Scandinavica, 91*(4), 233-235.

Azhar, M. Z., & Varma, S. L. (1995b). Religious psychotherapy in depressive patients. *Psychotherapy and Psychosomatics, 63*(3), 165-173.

Azhar, M. Z., Varma, S. L., & Dharap, A. S. (1994). Religious psychotherapy in anxiety disorder patients. *Acta Psychiatrica Scandinavica, 90*(1), 1-3.

Bachelor, A. (1988). How clients perceive therapist empathy: A content analysis of 'received' empathy. *Psychotherapy: Theory, Research, Practice, Training, 25*(2), 227-240.

Bachelor, A. (1995). Clients' perception of the therapeutic alliance: A qualitative analysis. *Journal of Counseling Psychology, 42*(3), 323-337.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852.

Ball, R. A., & Goodyear, R. K. (1991). Self-reported professional practices of Christian psychologists. *Journal of Psychology and Christianity, 10,* 144-153.

Belgrave, F. Z. (2002). Relational theory and cultural enhancement interventions for African American adolescent girls. *Public Health Report, 117*(1), 76-81.

Belgrave, F. Z., Chase-Vaughn, G., Gray, F., Addison, J. D., & Cherry, V. R. (2000). The effectiveness of a culture-and gender-specific intervention for increasing resiliency among African American preadolescent females. *Journal of Black Psychology, 26*(2), 133-147.

Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*(5), 746-758.

Bennett, S. K., & BigFoot-Sipes, D. S. (1991). American Indian and White college student preferences for counselor characteristics. *Journal of Counseling Psychology, 38*(4), 440-445.

Beretta, V., de Roten, Y., Stigler, M., Fischer, M., Despland, J., & Drapeau, M. (2005). The influence of patient's interpersonal schemas on early alliance building. *Swiss Journal of Psychology/Schweizerische Zeitschrift fur Psychologie/Revue Suisse de Psychologie, 63,* 13-20.

Bergin, A. E., & Jensen, J. P. (1990). Religiosity of psychotherapists: A national survey. *Psychotherapy: Theory, Research, Practice, Training, 27*(1), 3-7.

Bergin, A. E., & Lambert, M. J. (1978). The evaluation of outcomes in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.) (pp. 139-189). New York: Wiley.

Beutler, L. E. (1998). Identifying empirically supported treatments: What if we didn't? *Journal of Consulting and Clinical Psychology, 66* (1), 113-120.

Bieschke, K. J., McClanahan, M., Tozer, E., Grzegorek, J. L., & Park, J. (2000). Programmatic research on the treatment of lesbian, gay, and bisexual clients: The past, the present, and the course for the future. In R. M. Perez, K. A. DeBord & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay,*

and bisexual clients (pp. 309-335). Washington, DC US: American Psychological Association.

Binder, J. L., & Strupp, H. H. (1997). "Negative process": A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology: Science and Practice, 4,* 121-139.

Bischoff, R. J., & McBride, A. (1996). Client perceptions of couples and family therapy. *American Journal of Family Therapy, 24*(2), 117-128.

Bischoff, R. J., McKeel, A. J., Moon, S. M., & Sprenkle, D. H. (1996). Therapist-conducted consultation: Using clients as consultants to their own therapy. *Journal of Marital & Family Therapy, 22*(3), 359-379.

Bohart, A. C., & Tallman, K. (1999). *How clients make therapy work: The process of active self-healing*. Washington, D.C.: American Psychological Association.

Brooks, V. R. (1981). Sex and sexual orientation as variables in therapists' biases and therapy outcomes. *Clinical Social Work Journal, 9*(3), 198-210.

Brown, B. S., Joe, G. W., & Thompson, P. (1985). Minority group status and treatment retention. *International Journal of the Addictions, 20*(2), 319-335.

Bryan, L. A., Dersch, C., Shumway, S., & Arredondo, R. (2004). Therapy outcomes: Client perception and similarity with therapist view. *American Journal of Family Therapy, 32*(1), 11-26.

Burckell, L. A., & Goldfried, M. R. (2006). Therapist qualities preferred by sexual minority individuals. *Psychotherapy: Theory, research, Practice, Training, 43*(1), 32-49.

Burns, D. D. (1990). *The feeling good handbook.* New York: Plume.

Burns, D. D., & Auerbach, A. (1996). Therapeutic empathy in cognitive-behavioral therapy: Does it really make a difference? In P. M. Salkovskis (Ed.), *Frontiers of cognitive therapy* (pp. 135-164). New York: Guilford Press.

Buttny, R. (1990). Blame-accounts sequences in therapy: The negotiation of relational meanings. *Semiotica, 78,* 219-247.

Caldwell, L. D., & White, J. L. (2005). African-centered therapeutic and counseling interventions for African American males. In G. E. Good (Ed.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (pp. 737-753). San Francisco: Jossey-Bass.

Casas, J. M., Vasquez, M. J. T., & Ruiz de Esparza, C. A. (2002). Counseling the Latina/o: A guiding framework for a diverse population. In P. B. Pederson, J. G. Draguns. W. J. Lonner, & J. E. Trimble (Eds.), *Counseling across cultures* (5th ed.) (pp. 133-160). Thousand Oaks, CA: Sage.

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*(4), 521-536.

Charmaz, K. (2005). Grounded Theory in the 21st Century: Applications for Advancing Social Justice Studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.) (pp. 507-535). Thousand Oaks, CA: Sage Publications Ltd.

Chen, J., & Rizzo, J. (2010). Racial and ethnic disparities in use of psychotherapy: Evidence from U.S. national survey data. *Psychiatric Services, 61*(4), 364-372.

Chenail, R. J. (1993). Charting clinical conversations. In A. Rambo, A. Heath, & R. J. Chenail (Eds.), *Practicing therapy: Exercises for growing therapists* (pp. 169-224). New York: Norton.

Choudhuri, D. D. (2003). Qualitative research and multicultural counseling competency: An argument for inclusion. In D. B. Pope-Davis, H. L. K. Coleman, W. M. Liu & R. L. Toporek (Eds.), *Handbook of multicultural competencies: In counseling & psychology* (pp. 267-281). Thousand Oaks, CA US: Sage Publications, Inc.

Comas-Diaz, L. (2006). Cultural variation in the therapeutic relationship. In C. D. Goodheart, A. E. Kazdin, & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 81-105). Washington, DC: American Psychological Association.

Constantino, G., Malgady, R. G., & Rogler, L. H. (1986). Cuento therapy: A culturally sensitive modality for Puerto Rican children. *Journal of Consulting and Clinical Psychology, 54*, 639-645.

Constantino, G., Malgady, R. G., & Rogler, L. H. (1994). Storytelling through pictures: Culturally sensitive psychotherapy for Hispanic children and adolescents. *Journal of Clinical Child Psychology, 23*, 13-20.

Constantino, M. J., Castonguay, L. G., Zack, S. E., & DeGeorge, J. (2010). Engagement in psychotherapy: Factors contributing to the facilitation, demise, and restoration of the therapeutic alliance. In D. Castro-Blanco, & M. S. Karver (Eds.), *Elusive alliance: Treatment engagement strategies with high-risk adolescents* (pp. 21-57). Washington, DC: American Psychological Association.

Constantino, M., & Smith-Hansen, L. (2008). Patient interpersonal factors and the therapeutic alliance in two treatments for bulimia nervosa. *Psychotherapy Research, 18,* 683-698.

Council of National Psychological Associations for the Advancement of Ethnic Minority Interests. (2009). *Psychology education and training from culture-specific and multiracial perspectives.* APA Office of Ethnic Minority Affairs. www.apa.org/pi/oema.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd ed.). Thousand Oaks, CA US: Sage Publications, Inc.

Cross, W. E., & Cross, T. B. (2008). Theory, research, and models. In S. M. Quintana & C. McKown (Eds.), *Handbook of race, racism, and the developing child* (pp. 154-181). Hoboken, NJ: Wiley.

Cuijpers, P., van Straten, A., Andersson, G., & van Oppen, P. (2008). Psychotherapy for depression in adults: A meta-analysis of comparative outcome studies. *Journal of Consulting and Clinical Psychology, 76*(6), 909-922.

D'Andrea, M., & Heckman, E. F. (2008). A 40-year review of multicultural counseling outcome research: Outlining a future research agenda for the multicultural counseling movement. *Journal of Counseling & Development, 86*(3), 356-363.

Dauphinais, P., LaFromboise, T., & Rowe, W. (1980). Perceived problems and sources of help for American Indian students. *Counselor Education and Supervision, 20,* 37-46.

De Coteau, T., Anderson, J., & Hope, D. (2006). Adapting manualized treatments: Treating anxiety disorders among Native Americans. *Cognitive Behavioral Practice, 13*(4), 304-309.

Delaney, H. D., Miller, W. R., & Bisonó, A. M. (2007). Religiosity and spirituality among psychologists: A survey of clinician members of the American Psychological Association. *Professional Psychology: Research and Practice, 38*(5), 538-546.

de La Ronde, C., & Swann, W. B., Jr. (1993). Caught in the crossfire: Positivity and self-verification strivings among people with low self-esteem. In R. F. Baumeister (Ed.), *Self-esteem: The puzzle of low self regard* (pp. 147-165). New York: Plenum Press.

Denzin, N. K. (2005). Emancipatory Discourses and the Ethics and Politics of Interpretation. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.) (pp. 933-958). Thousand Oaks, CA: Sage Publications Ltd.

Denzin, N. K., & Lincoln, Y. S. (1994). Introduction: Entering the field of qualitative research. In N.K. Denzin & Y.S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 1-17). Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The Discipline and Practice of Qualitative Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.) (pp. 1-32). Thousand Oaks, CA: Sage Publications Ltd.

Diamond, L. M. (2003). New paradigms for research in heterosexual and sexual-minority development. *Journal of Clinical Child and Adolescent Psychology, 32*, 490-498.

Downing Hansen, N., Randazzo, K. V., Schwartz, A., Marshall, M., Kalis, D., Frazier, R., Burke, C., Kershner-Rice, K., & Norvig, G. (2006). Do we practice what we preach? An exploratory survey of multicultural psychotherapy competencies. *Professional Psychology: Research and Practice*, *37*(1), 66-74.

Dunkle, J. H. (1994). Counseling gay male clients: A review of treatment efficacy research: 1975-present. *Journal of Gay & Lesbian Psychotherapy, 2*(2), 1-19.

Eames, V., & Roth, A. (2000). Patient attachment orientation and the early working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10*, 421-434.

Elliott, R. (1986). Interpersonal Process Recall (IPR) as a psychotherapy process research method. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 503-527). New York, NY US: Guilford Press.

Elliott, R., & James, E. (1989). Varieties of Client Experience in Psychotherapy: An Analysis of the Literature. *Clinical Psychology, 9*, 443-467.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *The Journal of Consulting Psychology, 16*, 319-324.

Farsimadan, F., Draghi-Lorenz, R., & Ellis, J. (2007). Process and outcome of therapy in ethnically similar and dissimilar therapeutic dyads. *Psychotherapy Research*, *17*, 567-575.

Fitzpatrick, M. R., Janzen, J., Chamodraka, M., & Park, J. (2006). Client critical incidents in the process of early alliance development: A positive emotion–exploration spiral. *Psychotherapy Research*, *16*(4), 486-498.

Flaskerud, J. H. (1986). The effects of culture-compatible intervention on the utilization of mental health services by minority clients. *Community Mental Health Journal*, *22*(2), 127-141.

Flaskerud, J. H., & Hu, L.-t. (1994). Participation in and outcome of treatment for major depression among low income Asian-Americans. *Psychiatry Research, 53*(3), 289-300.

Fonagy, P., Steele, M., Steele, H., Higgitt, A., & Target, M. (1994). The Emmanuel Miller memorial lecture 1992: The theory and practice of resilience. *Journal of Child Psychology and Psychiatry, 35*, 231-257.

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins.

Fraser, J. S., & Solovey, A. D. (2007). *Second-order change in psychotherapy*. Washington, DC: American Psychological Association.

Freud, S. (1940). An outline of psycho-analysis. *The International Journal of Psychoanalysis, 21*, 27-84.

Fuertes, J. N., Bartolomeo, M., & Nichols, M. (2001). Future research directions in the study of counselor multicultural competency. *Journal of Multicultural Counseling and Development, 29*(1), 3-12.

Fuertes, J. N., Costa, C. I., Mueller, L. N., & Hersh, M. (2005). Psychotherapy process and outcome from a racial-ethnic perspective. In R. T. Carter (Ed.), *Handbook of racial-cultural psychology and counseling, Vol 1: Theory and research* (pp. 256-276). Hoboken, NJ US: John Wiley & Sons Inc.

Fuertes, J. N., Stracuzzi, T. I., Bennett, J., Scheinholtz, J., Mislowack, A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: A study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 480-490.

Fuertes, J. N., Mueller, L. N., Chauhan, R. V., Walker, J. A., & Ladany, N. (2002). An investigation of European American therapists' approach to counseling African American clients. *The Counseling Psychologist, 30*(5), 763-788.

Fujino, D. C., Okazaki, S., & Young, K. (1994). Asian-American women in the mental health system: An examination of ethnic and gender match between therapist and client. *Journal of Community Psychology, 22*(2), 164-176.

Furnham, A., & Swami, V. (2008). Patient preferences for psychological counsellors: Evidence of a similarity effect. *Counseling Psychology Quarterly, 21*(4), 361-370.

Gale, J. E. (1991). *Conversation analysis of therapeutic discourse: The pursuit of a therapeutic agenda*. Westport, CT US: Ablex Publishing.

Gale, J. E., & Newfield, N. (1997). A conversation analysis of a solution-focused marital therapy session. *Journal of Marital and Family Therapy, 18*(2) 153-165.

Gallop, G. Jr. (1995). The Gallop poll: Public opinion in 1995. Wilmington, DE: Scholarly Resources.

Gamst, G., Dana, R. H., Der-Karaberian, A., & Kramer, T. (2000). Ethnic match and client ethnicity effects on global assessment and visitation. *Journal of Community Psychology, 28*(5), 547-564.

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 190-228). Oxford England: John Wiley & Sons.

Gatz, M., Fiske, A., Fox, L. S., Kaskie, B., Kasl-Godley, J. E., McCallum, T. J., et al. (1998). Empirically validated psychological treatments for older adults. *Journal of Mental Health and Aging, 4*(1), 9-46.

Gelso, C. J. (2010). The diversity status of the psychotherapist: Editorial introduction. *Psychotherapy: Theory, Research, Practice, Training, 47*, 143.

Gelso, C. J., & Carter, J. A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist, 13*(2), 155-243.

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*, 266-275.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology: A modified Husserlian approach*. Pittsburgh, PA: Duquesne University Press.

Gloaguen, V., Cottraux, J., Cucherat, M., & Blackburn, I.-M. (1998). A meta-analysis of the effects of cognitive therapy in depressed patients. *Journal of Affective Disorders, 49*(1), 59-72.

Goin, M. K., Yamamoto, J., & Silverman, J. (1965). Therapy congruent with class-linked expectations. *Archives of General Psychiatry, 13*, 133-137.

Goldman, G. A., & Anderson, T. (2005). Quality of object relations and secure attachment as predictors of early therapeutic alliance. *Journal of Counseling Psychology, 54*, 111-117.

Greene, B. (2007). How difference makes a difference. In J. C. Muran (Ed.), *Dialogues on difference: Studies of diversity in the therapeutic relationship* (pp. 47-63). Washington, DC: American Psychological Association.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*, 372-378.

Griner, D., & Smith, T. B. (2006). Culturally adapted mental health intervention: A meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43*(4), 531-548.

Guba, E. G., & Lincoln, Y. S. (2008). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (3rd ed.) (pp. 255-286). Thousand Oaks, CA US: Sage Publications, Inc.

Gushue, G. V., & Constantine, M. G. (2007). Color-blind racial attitudes and White racial identity attitudes in psychology trainees. *Professional Psychology: Research and Practice, 38*(3), 321-328.

Gutierres, S. E., Russo, N. F., & Urbanski, L. (1994). Sociocultural and psychological factors in American Indian drug use: Implications for treatment. *International Journal of the Addictions, 29*(14), 1761-1786.

Gutierres, S. E., & Todd, M. (1997). The impact of childhood abuse on treatment outcomes of substance users. *Professional Psychology: Research and Practice, 28*(4), 348-354.

Harris Poll. (2004). *Therapy in America: A poll sponsored by Psychology Today and PacifiCare*. Retrieved September 23, 2011, from http://www.dearshrink.com/2004TherapyInAmerica.pdf.

Harvey, A. R., & Hill, R. B. (2004). Africentric youth and family rites of passage program: Promoting resilience among at-risk African American youths. *Social Work, 49*(1), 65-71.

Havilland, M. G., Horswill, R. K., O'Connell, J. J., & Dynneson, V. V. (1983). Native American college students' preference for counselor race and sex and the likelihood of their use of a counseling center. *Journal of Counseling Psychology, 30*, 267-270.

Hays, P. A. (2001). Addressing cultural complexities in practice: A framework for clinicians and counselors. Washington, DC: American Psychological Association.

Helms, J. E. (1995). An update of Helms's White and people of color model racial identity models. In J. G. Ponterotto, J. M. Casas, L. M. Suzuki, & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181-198). Thousand Oaks, CA: Sage.

Henrik, R. (Ed.) (1980). *The psychotherapy handbook: The A to Z guide to more than 250 different therapies in use today*. New York: Meridian.

Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research and practice* (pp. 51-84). New York: Wiley.

Hersoug, A. G., Hoglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *Journal of Psychotherapy Process and Research, 10,* 205-216.

Hill, C. E. (1975). Sex of client and sex and experience level of counselor. *Journal of Counseling Psychology, 22*(1), 6-11.

Hilliard, R. B., Henry, W. P., & Strupp, H. H. (2000). An interpersonal model of psychotherapy: Linking patient and therapist developmental history, therapeutic process and types of outcome. *Journal of Consulting and Clinical Psychology, 68,* 125-133.

Hilsenroth, M. J., & Cromer, T. D. (2007). Clinical interventions related to alliance during the initial interview and psychological assessment. *Psychotherapy: Theory, Research, Practice, Training, 44,* 205-218.

Hook, J. N., Worthington, E. L., Davis, D. E., Jennings, D. J., Gartner, A. L., & Hook, J. P. (2010). Empirically supported religious and spiritual therapies. *Journal of Clinical Psychology, 66,* 46-72.

Hopps, J., & Liu, W. M. (2006). Working for social justice from within the health care system: The role of social class in psychology. In R. L. Toporek, L. H. Gerstein, N. A. Fouad, G. Roysircar, & T. Israel (Eds.), *Handbook for social justice in counseling psychology: Leadership, vision, and action* (pp. 318–337). Thousand Oaks, CA: Sage.

Horvath, A. O. (2001). The alliance. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 365-372.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York, NY: Oxford University Press.

Horvath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*(2), 139-149.

Hubble, M. A, Duncan, B. L., & Miller, S. D. (1999). Introduction. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 1-32). Washington, D.C.: American Psychological Association.

Hubble, M. A, Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble, (Eds.), *The heart and soul of change: What works in therapy* (pp. 23-46). Washington, D.C.: American Psychological Association.

Imel, Z. E., Wampold, B. E., Miller, S. D., & Fleming, R. R. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors*, *22*(4), 533-543.

Joanides, C. J., Brigham, L., & Joanning, H. (1997). Co-creating a more cooperative client–therapist relationship through a debriefing process. *American Journal of Family Therapy, 25*(2), 139-150.

Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research & Practice, 15*(3), 226-236.

Jones, E. E. (1982). Psychotherapists' impressions of treatment outcome as a function of race. *Journal of Clinical Psychology, 38*(4), 722-731.

Jones, E. E., Krupnick, J. L., & Kerig, P. K. (1987). Some gender effects in a brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 24*(3), 336-352.

Jones, E. E., & Zoppel, C. L. (1982). Impact of client and therapist gender on psychotherapy process and outcome. *Journal of Consulting and Clinical Psychology, 50*(2), 259-272.

Jones, M. A., Botsko, M., & Gorman, B. S. (2003). Predictors of Psychotherapeutic Benefit of Lesbian, Gay, and Bisexual Clients: The Effects of Sexual Orientation Matching and Other Factors. *Psychotherapy: Theory, Research, Practice, Training*, *40*(4), 289-301.

Joyce, A. S., Wolfaardt, U., Sribney, C., & Aylwin, A. S. (2006). Psychotherapy research at the start of the 21st century: The persistence of the art versus science controversy. *Canadian Journal of Psychiatry, 51*(13), 797-809.

Karlsson, R. (2005). Ethnic Matching Between Therapist and Patient in Psychotherapy: An Overview of Findings, Together With Methodological and Conceptual Issues. *Cultural Diversity and Ethnic Minority Psychology*, *11*(2), 113-129.

Keating, A. M., & Fretz, B. R. (1990). Christians' anticipations about counselors in response to counselor descriptions. *Journal of Counseling Psychology, 37*(3), 293-296.

Kelly, D., & Roeddert, E. (2008). Racial cognition and ethics of implicit bias. *Philosophy Compass*, *3*, 522-540.

Kim, B. S. K., Ng, G. F., & Ahn, A. J. (2005). Effects of client expectation for counseling success, client-counselor worldview match, and client adherence to Asian and European American cultural values on counseling process with Asian Americans. *Journal of Counseling Psychology*, *52*, 67-76.

Kim, D. M., Wampold, B. E., & Bolt, D. M. (2006). Therapist effects in psychotherapy: A random effects modeling of the NIMH TDCRP data. *Psychotherapy Research, 16*, 161-172.

Kincheloe, J. L., & McLaren, P. L. (2000). Rethinking critical theory and qualitative research. In N. K. Denzin, & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) (pp. 279-313). Thousand Oaks, CA: Sage.

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. G. (2003). African American and European American therapists' experiences of addressing race in cross-racial psychotherapy dyads. *Journal of Counseling Psychology, 50*(4), 466-481.

Knox, S., Hess, S. A., Petersen, D. A., & Hill, C. E. (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. *Journal of Counseling Psychology, 44*(3), 274-283.

Kohn, L. P., Oden, T., Munoz, R. F., Robinson, A., & Leavitt, D. (2002). Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Mental Health Journal*, *38*(6), 497-504.

Kokotovic, A. M., & Tracey, T. J. (1990). Working alliance in early phase of counseling. *Journal of Counseling Psychology, 37*, 16-21.

Kottler, J. A., & Hunter, S. V. (2010). Clients as teachers: Reciprocal influences in therapy relationships. *ANZJFT Australian and New Zealand Journal of Family Therapy*, 31(1), 4-12.

Kuehl, B. P., Newfield, N. A., & Joanning, H. (1990). A client-based description of family therapy. *Journal of Family Psychology, 3*(3), 310-321.

Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing.* Thousand Oaks, CA: Sage.

LaFromboise, T. D., & Dixon, D. N. (1981). American Indian perception of trustworthiness in a counseling interview. *Journal of Counseling Psychology, 28*, 135-139.

Laing, R. D. (1967). *The politics of experience*. New York: Pantheon Books.

Lam, A. G., & Sue, S. (2001). Client diversity. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 479-486.

Lambert, M. J., & Archer, A. (2006). Research Findings on the Effects of Psychotherapy and their Implications for Practice. In C. D. Goodheart, A. E. Kazdin & R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet* (pp. 111-130). Washington, DC US: American Psychological Association.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy, 38*(4), 357-361.

Lambert, M. J., & Barley, D. E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 17-32). New York, NY US: Oxford University Press.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 143-189). Oxford England: John Wiley & Sons.

Lambert, M. J., Garfield, S. L., & Bergin, A. E. (2004). Overview, trends, and future issues. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.) (pp. 805-819). New York: Wiley.

Lambert, M. J., Smart, D. W., Campbell, M. P., Hawkins, E. J., Harmon, C., & Slade, K. L. (2006). Psychotherapy outcome, as measured by the OQ-45, in African American, Asian/Pacific Islander, Latino/a, and Native American clients compared with matched Caucasian clients. *Journal of College Student Psychotherapy, 20*(4), 17-29.

Lambert, M. T., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*, 72-79.

LaSala, M. C. (1997). Client satisfaction: Consideration of correlates and response bias. *Families in Society, 78*(1), 54-64.

Lau, A. S. (2006). Making the case for selective and directed cultural adaptations of evidence-based treatments: Examples from parent training. *Clinical Psychology: Science and Practice, 13*(4), 295-310.

Lau, A., & Zane, N. (2000). Examining the effects of ethnic-specific services: An analysis of cost-utilization and treatment outcome for Asian American clients. *Journal of Community Psychology, 28*(1), 63-77.

Lee, C. C. (1999). Counseling African American men. In L. E. Davis (Ed.), *Working with African American males: A guide to practice* (pp. 39-53). Thousand Oaks, CA: Sage.

Lee, W. M. L., & Mixson, R. J. (1995). Asian and Caucasian client perceptions of the effectiveness of counseling. *Journal of Multicultural Counseling and Development, 23*(1), 48-56.

Lerner, B. (1972). *Therapy in the ghetto: Political impotence and personal disintegration*. Baltimore, MD: Johns Hopkins University Press.

Levant, R. F., & Silverstein, L. B. (2006). Gender is neglected by both evidence-based practices and treatment as usual. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 338-345). Washington, DC: American Psychological Association.

Lichtenberg, J. W., Wettersten, K. B., Mull, H., Moberly, R. L., Merkley, K. B., & Corey, A. T. (1998). Relationship formation and relational control as correlates of psychotherapy quality and outcome. *Journal of Counseling Psychology, 45*(3), 322-337.

Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings on helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*(4), 394-401.

Lietaer, G. (1992). Helping and Hindering processes in client-centered/experiential psychotherapy: A content analysis of client and therapist postsession perceptions. In S. G. Toukmanian & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 134-162). Thousand Oaks, CA: Sage.

Liljestrand, P., Gerling, E., & Saliba, P. A. (1978). The effects of social sex-role stereotypes and sexual orientation on psychotherapeutic outcomes. *Journal of Homosexuality, 3*(4), 361-372.

Lipsey, M. W., & Wilson, D. B. (1993). The efficacy of psychological, educational, and behavioral treatment: Confirmation from meta-analysis. *American Psychologist, 48*(12), 1181-1209.

Liu, W. M., Soleck, G., Hopps, J., Dunston, K., & Pickett, T. (2004). A new framework to understand social class in counseling: The social class worldview and modern

classism theory. *Journal of Multicultural Counseling and Development, 32*, 95–122.

Longshore, D., & Grills, C. (2000). Motivating illegal drug use recovery: Evidence for a culturally congruent intervention. *Journal of Black Psychology, 26*(3), 288-301.

Lonigan, C. J., Elbert, J. C., & Johnson, S. B. (1998). Empirically supported psychosocial interventions for children: An overview. *Journal of Clinical Child Psychology, 27*(2), 138-145.

Lorion, R. P., & Felner, R. D. (1986). Research on psychotherapy with the disadvantaged. In S. L. Garfield, & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed.) (pp. 739-776). New York: Wiley.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy? Predicting therapeutic outcome*. New York: Basic Books.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that 'everyone has won and all must have prizes'? *Archives of General Psychiatry, 32*(8), 995-1008.

Maione, P. V., & Chenail, R. J. (1999). Qualitative inquiry in psychotherapy: Research on the common factors. In M. A. Hubble, B. L. Duncan & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. 57-88). Washington, DC US: American Psychological Association.

Malgady, R. G., Rogler, L. H., & Constantino, G. (1990). Culturally sensitive psychotherapy for Puerto Rican children and adolescents: A program of treatment outcome research. *Journal of Consulting and Clinical Psychology, 58*(6), 704-712.

Manson, S. M., Walker, R. D., & Kivlahan, D. R. (1987). Psychiatric assessment and treatment of American Indians and Alaska Natives. *Hospital & Community Psychiatry, 38*(2), 165-173.

Markowitz, J. C., Spielman, L. A., Sullivan, M., & Fishman, B. (2000). An exploratory study of ethnicity and psychotherapy outcome among HIV-positive patients with depressive symptoms. *Journal of Psychotherapy Practice & Research, 9*(4), 226-231.

Marmar, C. R, Weiss, D. S., & Gaston, L. (1989). Toward a validation of the California Psychotherapy Alliance Rating System. *Psychological Assessment, 1*, 46-52.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-450.

McCollum, E. E., & Trepper, T. S. (1995). 'Little by little, pulling me through': Women's perceptions of successful drug treatment: A qualitative inquiry. *Journal of Family Psychotherapy, 6*(1), 63-82.

McCullough, M. E. (1999). Research on religion-accommodative counseling: Review and meta-analysis. *Journal of Counseling Psychology, 46*(1), 92-98.

Meltzoff, J., & Kornreich, M. (1970). *Research in psychotherapy*. New Brunswick, NJ US: AldineTransaction.

Metcalf, L., Thomas, F., Duncan, L., Miller, S., & Hubble, M. (1996). What works in solution-focused brief therapy: A qualitative analysis of client and therapist perceptions. In S. Miller, M. Hubble, & B. Duncan (Eds.), *Handbook of solution focused brief therapy* (pp. 335-349). San Francisco: Jossey-Bass.

Miles, M. B., & Huberman, A.M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage.

Miller, G. (1987). Producing family problems: Organization and uses of the family perspective and rhetoric in family therapy. *Symbolic Interaction, 10*(2), 245-265.

Miller, G., & Silverman, D. (1995). Troubles talk and counseling discourse: A comparative study. *The Sociological Quarterly, 36*(4), 725-747.

Miller, S. D., Duncan, B. L., & Hubble, M. A. (2005). Outcome informed clinical work. In J. Norcross & M. Goldfried (Eds.), *Handbook of Psychotherapy Integration* (2nd ed.) (pp.84-102). New York: Oxford University Press.

Miller, S., Wampold, B., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research, 18*(1), 5-14.

Miller, W. R., Wilbourne, P. L., & Hettema, J. E. (2003). What works? A summary of alcohol treatment outcome research. In R. K. Hester & W. R. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed.) (pp. 13-63). Boston, MA: Allyn & Bacon.

Miranda, J., Azocar, F., Organista, K., Dwyer, E., & Areane, P. (2003). Treatment of depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services, 54,* 219-225.

Morales, E., & Norcross, J. C. (2010). Evidence-based practice with ethnic minorities: Strange bedfellows no more. *Journal of Clinical Psychology: In Session, 66*(8), 821-829.

Morrow, S. L. (1992). Voices: Constructions of survival and coping by women survivors of child sexual abuse. (Doctoral dissertation, Arizona State University). *Dissertation Abstracts International*, 53, 5989.

Morrow, S. L. (2000). First do no harm: Therapist issues in psychotherapy with lesbian, gay, and bisexual clients. In Perez, R. M., DeBord, K. A., & Bieschke, K. J. (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 137-156). Washington, DC: American Psychological Association.

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist, 35*(2), 209-235.

Morrow, S. L., Rakhsha, G., & Castañeda, C. L. (2001). Qualitative research methods for multicultural counseling. In J. G. Ponterotto, J. M. Casas, L. A. Suzuki & C. M. Alexander (Eds.), *Handbook of multicultural counseling* (2nd ed.) (pp. 575-603). Thousand Oaks, CA US: Sage Publications, Inc.

Morrow, S. L., & Smith, M. L. (2000). Qualitative research for counseling psychology. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed.) (pp. 199-230). New York: Wiley.

Moustakas, C. E. (1994). *Phenomenological research methods*. Thousand Oaks, CA US: Sage Publications, Inc.

Muran, C. J. (2007). Positioning the editor: An introduction to difference and dialogue. In C. J. Muran (Ed.), *Dialogues on difference: Studies of diversity in the therapeutic relationship* (pp. 3-12). Washington, DC: American Psychological Association.

Muran, J. C., Safran, J. D., Gorman, B. S., Eubanks-Carter, C., Winston, A., & Samstag, L. W. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training*, *46*, 233-248.

Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on psychotherapy efficacy and effectiveness: Between Scylla and Charybdis? *Psychological Bulletin, 126*(6), 964-981.

Nevo, R. (2002). Interpersonal problems as they affect the development of therapeutic alliance and group climate in group psychotherapy for women survivors of childhood sexual abuse (Doctoral dissertation, Pacific Graduate School of Psychology, 2002). *Dissertation Abstracts International*, *63*, 3-B.

Nezu, A. M. (2010). Cultural influences on the process of conducting psychotherapy: Personal reflections of an ethnic minority psychologist. *Psychotherapy: Theory, Research, Practice, Training*, *47*, 169-176.

Nhat Hanh, T. (1975). *The Miracle of Mindfulness*. Boston: Beacon Press.

Norcross, J. C. (1999). Foreword. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.), *The heart and soul of change: What works in therapy* (pp. xvii-xx). Washington, D.C.: American Psychological Association.

Norcross, J. C. (Ed.). (2001). Empirically supported therapy relationships: Summary report of the Division 29 Task Force. *Psychotherapy, 38*(4).

Norcross, J. C. (2002). Empirically supported therapy relationships. In J. C. Norcross (Ed.), *Psychotherapy relationships that work* (pp. 3-16). New York: Oxford University Press.

Norcross, J. C. & Lambert, M. J. (2005). The therapy relationship. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 208-217). Washington, DC: American Psychological Association.

Norcross, J. C. & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*(1), 4-8.

Norcross, J. C. & Wampold, B. E. (2011). Evidence-based relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102.

Ogrodniczuk, J. S., Piper, W. E., & Joyce, A. S. (2004). Differences in Men's and Women's Responses to Short-Term Group Psychotherapy. *Psychotherapy Research, 14*(2), 231-243.

Ogrodniczuk, J. S., Piper, W. E., Joyce, A. S., & McCallum, M. (2001). Effect of patient gender on outcome in two forms of short-term individual psychotherapy. *Journal of Psychotherapy Practice & Research, 10*(2), 69-78.

Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for super-shrink: An empirical analysis of therapist effects. *Clinical Psychology & Psychotherapy, 10*, 361-373.

Olesen, V. (2005). Early millennial feminist qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.) (pp. 235-278). Thousand Oaks, CA: Sage.

Organista, K. C., Muñoz, R. F., & González, G. (1994). Cognitive-behavioral therapy for depression in low-income and minority medical outpatients: Description of a program and exploratory analyses. *Cognitive Therapy and Research, 18*(3), 241-259.

Orlinsky, D. E. (2006). Comments on the state of psychotherapy research (as I see it). *Psychotherapy Bulletin*, 41, 37-41.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1980). Process and outcome in psychotherapy: Noch einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed.) (pp. 270-376). Oxford England: John Wiley & Sons.

Orlinsky, D. E., & Howard, K. I. (1994). Gender and psychotherapeutic outcome. In A. M. Brodsky & R. T. Hare-Mustin (Eds.), *Women and psychotherapy: An assessment of research and practice* (pp. 3-34). New York: Guilford.

Orlinsky, D. E., & Howard, K. I. (1976). The effects of sex of therapist on the therapeutic experiences of women. *Psychotherapy: Theory, Research & Practice, 13*(1), 82-88.

Orlinsky, D. E., Ronnestad, M. H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed.) (pp. 307-390). New York: Wiley.

Owen, J., Leach, M. M., Wampold, B., & Rodolfa, E. (2011). Multicultural approaches in psychotherapy: A rejoinder. *Journal of Counseling Psychology, 58*(1), 22-26.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage.

Paivio, S. C., & Bahr, L. M. (1998). Interpersonal problems, working alliance and outcome in short-term experiential therapy. *Psychotherapy Research, 8*, 392-407.

Pecnik, J. A., & Epperson, D. L. (1985). Analogue study of expectations for Christian and traditional counseling. *Journal of Counseling Psychology, 32*(1), 127-130.

Pekarik, G. (1991). Relationship of expected and actual treatment duration for adult and child clients. *Journal of Clinical Child Psychology, 20*(2), 121-125.

Penn, Schoen, & Berland Associates. (2004, February 11). *Survey for the American Psychological Association*. Unpublished data.

Perez, R. M., DeBord, K. A., & Bieschke, K. J. (Eds.). (2000). *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients*. Washington, DC: American Psychological Association.

Polkinghorne, D. E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, 52(2), 137-145.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52 (2), 126-136.

Ponterotto, J. G., Fuertes, J. N., & Chen, E. C. (2000). Models of multicultural counseling. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed) (pp. 639-669). Hoboken, NJ US: John Wiley & Sons Inc.

Pope-Davis, D. B., Liu, W. M., Toporek, R. L., & Brittan-Powell, C. S. (2001). What's missing from multicultural competency research: Review, introspection, and recommendations. *Cultural Diversity and Ethnic Minority Psychology, 7*(2), 121-138.

Pope-Davis, D. B., Toporek, R. L., Ortega-Villalobos, L., Ligiéro, D. P., Brittan-Powell, C. S., Liu, W. M., et al. (2002). Client perspectives of multicultural counseling competence: A qualitative examination. *The Counseling Psychologist, 30*(3), 355-393.

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65*(2), 131-146.

Propst, L. R. (1980). The comparative efficacy of religious and nonreligious imagery for the treatment of mild depression in religious individuals. *Cognitive Therapy and Research, 4*(2), 167-178.

Propst, L. R., Ostrom, R., Watkins, P., Dean, T., & Mashburn, D. (1992). Comparative efficacy of religious and nonreligious cognitive-behavioral therapy for the treatment of clinical depression in religious individuals. *Journal of Consulting and Clinical Psychology, 60*(1), 94-103.

Puschner, B., Bauer, S., Horowitz, L. M., & Kordy, H. (2005). The relationship between interpersonal problems and the helping alliance. *Journal of Clinical Psychology, 61*, 415-419.

Query, J. N. (1985). Comparative admission and follow-up study of American Indians and Whites in a youth chemical dependency unit on the north central plains. *International Journal of the Addictions*, *20*(3), 489-502.

Quinones, M. E. (2007). Bridging the gap. In J. C. Muran (Ed.), *Dialogues on difference: Studies of diversity in the therapeutic relationship* (pp. 153-167). Washington, DC: American Psychological Association.

Raphel, M. M. (2001). The status of the use of spiritual interventions in three professional mental health groups. (Doctoral dissertation, Loyola College, Maryland, 2001). *Dissertation Abstracts International*, *62*(2), 779A.

Reis, B. F., & Brown, L. G. (1999). Reducing psychotherapy dropouts: Maximizing perspective convergence in the psychotherapy dyad. *Psychotherapy: Theory, Research, Practice, Training, 36*(2), 123-136.

Rennie, D. L. (1992). Qualitative analysis of client's experience of psychotherapy: The unfolding of reflexivity. In S. G. Toukmanian & D. L. Rennie (Eds.), *Psychotherapy process research: Paradigmatic and narrative approaches* (pp. 211-233). Thousand Oaks, CA US: Sage Publications, Inc.

Rennie, D. L. (2004). Anglo-North American Qualitative Counseling and Psychotherapy Research. *Psychotherapy Research, 14*(1), 37-55.

Rhodes, R. H., Hill, C. E., Thompson, B. J., & Elliott, R. (1994). Client retrospective recall of resolved and unresolved misunderstanding events. *Journal of Counseling Psychology, 41*(4), 473-483.

Richards, P. S., & Bergin, A. E. (2000). Toward religious and spiritual competency for mental health professionals. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 3-26). Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (2005). *A spiritual strategy for counseling and psychotherapy* (2nd ed.). Washington, DC: American Psychological Association.

Richards, P. S. & Potts, R. W. (1995). Using spiritual interventions in psychotherapy: Practices, successes, failures, and ethical concerns of Mormon psychotherapists. *Professional Psychology: Research and Practice*, *26*, 163-170.

Richards, P. S., & Worthington, E. L., Jr. (2010). The need for evidence-based, spiritually oriented psychotherapies. *Professional Psychology: Research and Practice, 41*(5), 363-370.

Richardson, L., & St. Pierre, E. A. (2005). Writing: A Method of Inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed.) (pp. 959-978). Thousand Oaks, CA: Sage Publications Ltd.

Ricker, M., Nystul, M., & Waldo, M. (1999). Counselors' and clients' ethnic similarity and therapeutic alliance in time-limited outcomes of counseling. *Psychological Reports*, *84*, 674-676.

Rinfret-Raynor, M., & Cantin, S. (1997). Feminist therapy for battered women: An assessment. In G. K. Kantor & J. L. Jasinski (Eds.), *Out of darkness: Contemporary perspectives on family violence* (pp. 219-234). Thousand Oaks, CA US: Sage Publications, Inc.

Ripley, J. S., Worthington, E. L., Jr., & Berry, J. W. (2001). The effects of religiosity on preferences and expectations for marital therapy among married Christians. *American Journal of Family Therapy, 29*(1), 39-58.

Rosenheck, R., Fontana, A., & Cottrol, C. (1995). Effect of clinician-veteran racial pairing in the treatment of posttraumatic stress disorder. *American Journal of Psychiatry, 152*(4), 555-563.

Rosenthal, C. (2000). Latino practice outcome research: A review of the literature. *Smith College Studies in Social Work, 70*(2), 217-238.

Rossello, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology, 67*, 734-745.

Rossello, J., Bernal, G., & Rivera-Medina, C. (2008). Individual and group CBT and IPT for Puerto Rican adolescents with depressive symptoms. *Cultural Diversity and Ethnic Minority Psychology, 14*(3), 234-245.

Roysircar, G., Hubbell, R., & Gard, G. (2003). Multicultural research on counselor and client variables: A relational perspective. In D. Pope-Davis, H. L. K. Coleman, W. M. Liu, & R. L. Toporek (Eds.), *Handbook of multicultural competencies* (pp 247-282). Thousand Oaks, CA: Sage.

Rubin, L. B. (1983). *Intimate strangers*. New York: Harper & Row.

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative interviewing: The art of hearing data* (2nd ed.) (pp. 152-172). Thousand Oaks, CA: Sage.

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64*, 447-458.

Satterfield, J. M. (1998). Cognitive behavioral group therapy for depressed, low-income minority clients: Retention and treatment enhancement. *Cognitive and Behavioral Practice, 5*(1), 65-80.

Schwandt, T. A. (2007). *The sage dictionary of qualitative inquiry* (3rd ed.). Thousand Oaks, CA: Sage.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and social sciences*. New York: Teachers College Press.

Shadish, W. R., Navarro, A. M., Matt, G. E., & Phillips, G. (2000). The effects of psychological therapies under clinically representative conditions: A meta-analysis. *Psychological Bulletin, 126*(4), 512-529.

Shafranske, E. P. (2000). Religious involvement and professional practices of psychiatrists and other mental health professionals. *Psychiatric Annals, 30*, 525-532.

Shattell, M. M., Starr, S. S., & Thomas, S. P. (2007). 'Take my hand, help me out': Mental health service recipients' experience of the therapeutic relationship. *International Journal of Mental Health Nursing, 16*(4), 274-284.

Sherman, G. D., & Clore, G. L. (2009). The color of sin: White and black are perceptual symbols of moral purity and pollution. *Psychological Science, 20*, 1019-1025.

Shilts, L., Rambo, A., & Hernandez, L. (1997). Clients helping therapists find solutions to their therapy. *Contemporary Family Therapy: An International Journal, 19*(1), 117-132.

Sikkema, K. J., Hansen, N. B., Kochman, A., Tate, D. C., & Difranceisco, W. (2004). Outcomes from a randomized controlled trial of a group intervention for HIV positive men and women coping with AIDS-related loss and bereavement. *Death Studies, 28*(3), 187-209.

Sirkin, M., Maxey, J., Ryan, M., & French, C. (1988). Gender awareness group therapy: Exploring gender-related issues in a day-treatment population. *International Journal of Partial Hospitalization, 5*(3), 263-272.

Smith, T. B., Bartz, J. D., & Richards, P. S. (2007). Outcomes of religiousand spiritual adaptations to psychotherapy: A meta-analytic review. *Psychotherapy Research, 17*, 643-655.

Sperry, L., Brill, P. L., Howard, K. I., & Grissom, G. R. (1996). *Treatment outcomes in psychotherapy and psychiatric interventions*. Philadelphia, PA US: Brunner/Mazel.

Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart, & Winston.

Stancombe, J., & White, S. (1997). Notes on the tenacity of therapeutic presuppositions in process research: Examining the artfulness of blamings in family therapy. *Journal of Family Therapy, 19*(1), 21-41.

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., Agnew-Davies, R., . . . Barkham, M. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships *U*-shaped or *V*-shaped? *Journal of Counseling Psychology, 51*, 81-92.

Strauss, A. L. (1987). *Qualitative analysis for social scientists.* Cambridge: Cambridge University Press.

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Multicultural Counseling and Development, 20*(2), 64-88.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53*, 440-448.

Sue, S. (2003). In Defense of Cultural Competency in Psychotherapy and Treatment. *American Psychologist, 58*(11), 964-970.

Sue, S., Fujino, D. C., Hu, L.-t., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59*(4), 533-540.

Sue, S., & Lam, A. G. (2002). Cultural and demographic diversity. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 401-421). New York, NY US: Oxford University Press.

Sue, S., & Zane, N. (2006). Ethnic minority populations have been neglected by evidence-based practices. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions* (pp. 329-337). Washington, DC: American Psychological Association.

Sue, S., Zane, N., Nagayama Hall, G. C., & Berger, L. K. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change (4th ed.)* (pp. 783-817). Oxford England: John Wiley & Sons.

Szapocznik, J., Rio, A., Murray, E., Cohen, R., Scopetta, M., Rivas-Vazquez, A., et al. (1989). Structural family versus psychodynamic child therapy for problematic Hispanic boys. *Journal of Consulting and Clinical Psychology, 57*(5), 571-578.

Takeuchi, D. T., Sue, S., & Yeh, M. (1995). Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles. *American Journal of Public Health, 85*(5), 638-643.

Talley, J. E., Butcher, T., Maguire, M. A., & Pinkerton, R. S. (1992). The effects of very brief psychotherapy on symptoms of dysphoria. In J. E. Talley (Ed.), *The predictors of successful very brief psychotherapy: A study of differences by*

gender, age, and treatment variables (pp. 12-45). Springfield, IL England: Charles C Thomas, Publisher.

Task Force for the Development of Guidelines for the Provision of Humanistic Psychosocial Services. (1997). Guidelines for the provision of humanistic psychosocial services. *Humanistic Psychologist, 25*, 65-107.

Timulak, L. (2007). Identifying core categories of client-identified impact of helpful events in psychotherapy: A qualitative meta-analysis. *Psychotherapy Research, 17*(3), 305-314.

Todd, T. A., Joanning, H., Enders, L., & Mutchler, L. (1990). Using ethnographic interviews to create a more cooperative client-therapist relationship. *Journal of Family Psychotherapy, 1*(3), 51-63.

Tolman, D. L., & Brydon-Miller, M. (2001). *From subjects to subjectivities: A handbook of interpretive and participatory methods*. New York, NY US: New York University Press.

Troemel-Ploetz, S. (1977). 'She is just not an open person': A linguistic analysis of a restructuring intervention in family therapy. *Family Process, 16*(3), 339-352.

U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. (2001). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the Surgeon General – Executive Summary*. Rockville, MD: Author.

U.S. Census Bureau, Population Division, Population Estimates Program. (2000). *Population estimates for counties by race and Hispanic origin*. Retrieved January 14, 2012 from http://www.census.gov/population/estimates/county/crh/crhut98.txt.

Utsey, S. O., Gernat, C. A., & Hammar, L. (2005). Examining White counselor trainees' reactions to racial issues in counseling and supervision dyads. *Counseling Psychologist, 33*, 449-478.

van Ryn, M., & Fu, S. S. (2003). Paved with good intentions: Do public health and human service providers contribute to racial/ethnic disparities in health? *American Journal of Public Health, 93*(2), 248-255.

Vandevelde, S., Vanderplasschen, W., & Broekaert, E. (2003). Cultural responsiveness in substance-abuse treatment: A qualitative study using professionals' and clients' perspectives. *International Journal of Social Welfare, 12*(3), 221-228.

Vasquez, M, J. T., (2007). Cultural difference and the therapeutic alliance: An evidence-based analysis. *American Psychologist, 62*(8), 878-885.

Vivino, B. L., Thompson, B. J., Hill, C. E., & Ladany, N. (2009). Compassion in psychotherapy: The perspective of therapists nominated as compassionate. *Psychotherapy Research, 19*(2), 157-171.

Wampold, B. E. (2000). Outcomes of individual counseling and psychotherapy: Empirical evidence addressing two fundamental questions. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (3rd ed.) (pp. 711-739). Hoboken, NJ US: John Wiley & Sons Inc.

Wampold, B. E. (2001). *The great psychotherapy debate*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62*, 857-873.

Wampold, B. E. (2010). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble, (Eds.), *The heart and soul of change: What works in therapy* (pp. 49-82). Washington, D.C.: American Psychological Association.

Wampold, B. E., & Bhati, K. S. (2004). Attending to the omissions. *Professional Psychology: Research and Practice, 35*, 563-570.

Wampold, B. E., Lichtenberg, J. W., & Waehler, C. A. (2002). Principles of empirically supported interventions in counseling psychology. *The Counseling Psychologist, 30*(2), 197-217.

Wampold, B. E., Minami, T., Baskin, T. W., & Tierney, S. C. (2002). A meta - (re) analysis of the effects of cognitive therapy versus 'other therapies' for depression. *Journal of Affective Disorders, 68*(2), 159-165.

Warburton, J., Newberry, A., & Alexander, J. (1989). Women as therapists, trainees, and supervisors. In M. McGoldrick, C. M. Anderson & F. Walsh (Eds.), *Women in families: A framework for family therapy* (pp. 152-165). New York, NY US: W W Norton & Co.

Ward, M. R., Linville, D. C., & Rosen, K. H. (2007). Clients' Perceptions of the Therapeutic Process: A Common Factors Approach. *Journal of Couple & Relationship Therapy*, 6(3), 25-43.

Watson, J. C., & Greenberg, L. S. (1994). The alliance in experiential therapy: Enacting the relationship conditions. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 153-172). Oxford, England: Wiley.

Weitz, R. (1982). Feminist consciousness raising, self-concept, and depression. *Sex Roles, 8*(3), 231-241.

Wertz, F. J. (2005). Phenomenological Research Methods for Counseling Psychology. *Journal of Counseling Psychology, 52*(2), 167-177.

Westra, H. A., Aviram, A., Connors, L., Kertes, A., & Ahmed, M. (2011). Therapist emotional reactions and client resistance in cognitive behavioral therapy. *Psychotherapy*, 10, 1-10.

Whaley, A. L. (2001). Cultural mistrust of White mental health clinicians among African Americans with severe mental illness. *American Journal of Orthopsychiatry, 71*, 252-256.

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice, 24*(2), 190-195.

Wikler, M. (1989). The religion of the therapist: It's meaning to Orthodox Jewish clients. *Hillside Journal of Clinical Psychiatry, 11*(2), 131-146.

Williams, D., & Levitt, H. M. (2008). Clients' experiences of difference with therapists: Sustaining faith in psychotherapy. *Psychotherapy Research, 18*(3), 256-270.

Williams, D. R., & Rucker, T. (1996). Socioeconomic status and the health of racial minority populations. In P. M. Kato & T. Mann (Eds.), *Handbook of diversity issues in health psychology* (pp. 407-423). New York, NY US: Plenum Press.

Winefield, H. R., Chandler, M. A., & Bassett, D. L. (1989). Tag questions and powerfulness: Quantitative and qualitative analyses of a course of psychotherapy. *Language in Society, 18*(1), 77-86.

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology, 70*, 21-43.

Wong, E. C., Beutler, L. E., & Zane, N. W. (2007). Using mediators and moderators to test assumptions underlying culturally sensitive therapies: An exploratory example. *Cultural Diversity & Ethnic Minority Psychology, 13*, 169-177.

Worthington, E. L., Jr., & Aten, J. D. (2009). Psychotherapy with religious and spiritual clients: An introduction. *Journal of Clinical Psychology, 65*(2), 123-130.

Worthington, E. L., Jr., Hook, J. N., Davis, D. E., & McDaniel, M. A. (2011). Religion and spirituality. In J. C. Norcross (Ed.), *Relationships that work* (2nd ed.). New York, NY: Oxford University Press.

Worthington, E. L., Jr., Kurusu, T. A., McCollough, M. E., & Sandage, S. J. (1996). Empirical research on religion and psychotherapeutic processes and outcomes: A 10-year review and research prospectus. *Psychological Bulletin, 119*(3), 448-487.

Worthington, E. L., Jr., & Sandage, S. J. (2001). Religion and spirituality. *Psychotherapy, 38*, 473-478.

Worthington, E. L., Jr., & Sandage, S. J. (2002). Religion and spirituality. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 383-399). New York, NY US: Oxford University Press.

Wyatt, S. C., & Johnson, R. W. (1990). The influence of counselors' religious values on clients' perceptions of the counselor. *Journal of Psychology & Theology, 18*(2), 158-165.

Zane, N. (1983, August). *Evaluation of outpatient psychotherapy for Asian and non-Asian American clients*. Paper presented at the American Psychological Association Conference, Anaheim, CA.

Zlotnick, C., Elkin, I., & Shea, M. T. (1998). Does the gender of a patient or the gender of a therapist affect the treatment of patients with major depression? *Journal of Consulting and Clinical Psychology, 66*(4), 655-659.

Zur, O. (2009). Therapeutic boundaries and effective therapy: Exploring the relationships. In W. T. O'Donahue & S. R. Graybar (Eds.), *Handbook of contemporary psychotherapy: Toward an improved understanding of effective psychotherapy* (pp. 341-357). Thousand Oaks, CA: Sage.

Zuroff, D. C., Blatt, S. J., Sotsky, S. M., Krupnick, J. L., Martin, D. J., Sanislow, C. A., & Simmens, S. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment of depression. *Journal of Consulting and Clinical Psychology, 68*, 114-124.